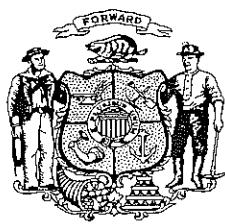


# STATE OF WISCONSIN

SENATE CHAIR  
MARK MILLER

317 East, State Capitol  
P.O. Box 7882  
Madison, WI 53707-7882  
Phone: (608) 266-9170



ASSEMBLY CHAIR  
MARK POCAN

309 East, State Capitol  
P.O. Box 8952  
Madison, WI 53708-8952  
Phone: (608) 266-8570

## JOINT COMMITTEE ON FINANCE

### MEMORANDUM

To: Members  
Joint Committee on Finance

From: Senator Mark Miller  
Representative Mark Pocan

Date: December 27, 2010

Re: DHS Report to JFC

As required by 2009 Act 28, Section 1301e, this letter provides a brief summary of the Southeast Wisconsin HMO plans for implementing Patient-Centered Medical Homes for high-risk pregnant women in their service area. I have also attached a copy of each of the four complete plans for your information as well as a copy of the relevant HMO contract language.

This report is being provided for your information only. No action by the Committee is required. Please feel free to contact us if you have any questions.

Attachments

MM:MP:jm



State of Wisconsin  
Department of Health Services

Jim Doyle, Governor  
Karen E. Timberlake, Secretary

RECEIVED  
DEC 27 2010

BY: St. Finance

December 22, 2010

The Honorable Mark Miller, Co-Chair  
Joint Committee on Finance  
317 East, State Capitol  
Madison, WI 53702

The Honorable Mark Pocan, Co-Chair  
Joint Committee on Finance  
309 East, State Capitol  
Madison, WI 53702

Dear Senator Miller and Representative Pocan:

As required by 2009 Act 28, Section 1301e, this letter provides a brief summary of the Southeast Wisconsin HMO plans for implementing Patient-Centered Medical Homes for high-risk pregnant women in their service area. I have also attached a copy of each of the four complete plans for your information as well as a copy of the relevant HMO contract language.

The four BadgerCare Plus-contracted health plans in SE Wisconsin are: Abri Health Plan, Children's Community Health Plan, CommunityConnect Healthplan and United Healthcare. These four HMOs were selected through a Request for Proposal to serve BadgerCare Plus members enrolled in the Standard and Benchmark plans in Milwaukee County and the five surrounding counties.

I am pleased to report that all four health plans are working together on this initiative and have jointly recruited several clinics to serve as medical home pilot sites. The sites serve predominately low-income, minority populations and provide comprehensive prenatal and postpartum care for high-risk women. A list of the sites is enclosed for your information.

The medical home pilots will begin operation on January 1, 2011 and continue through the life of the current contract, December 30, 2013. By contract, each HMO is required to enroll a minimum of 100 women in the medical homes in year one, 200 per HMO in year two and 300 per HMO in year three. DHS anticipates much higher enrollment rates by the second year of the pilot.

The implementation plans met and, often exceeded, requirements specified in the contract. DHS is pleased with proposed comprehensive efforts to identify women who may benefit from participating in a medical home, including extensive work with community-based organizations to assist with outreach. The plans include a range of incentives designed to help ensure that women remain enrolled in the medical home throughout their pregnancy and through the

Senator Miller and Representative Pocan

December 22, 2010

Page 2

postpartum period. Centering Pregnancy, an evidence-based program providing group-based care for women with similar due dates, is a key component of patient engagement strategies.

Each implementation plan describes appropriate protocols for ensuring that women keep appointments and for follow-up for missed appointments, including home visits, personal phone calls and the use of collateral contacts. Each plan also emphasizes that an obstetric care provider will be the primary point of contact for the pregnant woman and will be responsible for coordinating all needed care among multi-disciplinary teams. Protocols appear to be in place for ensuring immediate access to care and 24/7 access to medical advice.

Each participating clinic follows prenatal and postpartum guidelines issued by the American College of Obstetrics and Gynecology and other nationally-recognized guidelines for treating women with chronic conditions such as diabetes and hypertension. Care coordinators will work with each clinic to ensure that each BadgerCare Plus member enrolled in the medical home receives the services and supports she needs to have a healthy baby.

Throughout the medical home initiative, the HMOs will monitor and report on a number of performance measures, including three HEDIS (Healthcare Effectiveness Data and Information Set) measures—early prenatal care, frequency of prenatal care and postpartum care—as well as patient satisfaction. Performance information will be shared regularly with practices, providers and patients.

DHS is working collaboratively with the HMOs to develop a comprehensive evaluation of the medical home pilots for high-risk pregnant women. We would be happy to share the evaluation plan when it is completed.

Please feel free to contact Jason Helgerson, Medicaid Director and Administrator, Division of Health Care Access and Accountability, [Jason.Helgerson@wi.gov](mailto:Jason.Helgerson@wi.gov) or 608.267.9466, if you have any questions or need additional information.

Sincerely,

Karen E. Timberlake  
Secretary

Enclosures

## Medical Home Pilot sites

### Children's Community Health Plan

1. Sixteenth Street Community Health Center  
1032 S. Cesar E. Chavez Dr.  
Milwaukee
2. Medical College of Wisconsin/MCW Family Medicine
  - Columbia St. Mary's Family Practice Center  
1121 E North Avenue  
Milwaukee
  - St. Joseph's Family Care Center  
(aka Wheaton Franciscan-Glendale/Family Medicine Residency)  
2400 Villard Ave  
Milwaukee
  - Waukesha Family Practice Center  
210 N W Barstow  
Waukesha
3. Wheaton Franciscan St. Joseph's OB Residency Program/Women's Health Center  
50000 W Chambers  
Milwaukee
4. LifeTime OB/GYN  
17280 W North Ave  
Brookfield

### Abri Health Plan

1. Sixteenth Street Community Health Center
2. Wheaton Franciscan St. Joseph's OB Residency Program/ Women's Health Center
3. LifeTime OB/GYN
4. Columbia St. Mary's Residency Clinic  
2320 N. Lake Drive  
Milwaukee

CommunityConnect Health Plan

1. Sixteenth Street Community Health Center
2. Wheaton Franciscan St. Joseph's Hospital Women's Health Center
3. Aurora Health Center  
W 231 N1440 Corporate Ct  
Waukesha
4. Aurora Midwifery & Wellness Center  
925 N 12<sup>th</sup> Street  
Milwaukee
5. Westside Health Association
  - Lisbon Avenue Health Center  
3522 W Lisbon Avenue  
Milwaukee
  - Hillside Family Health Center  
1452 N 7<sup>th</sup> St  
Milwaukee

United Healthcare

1. Sixteenth Street Community Health Center
2. Wheaton Franciscan St. Joseph's OB Residency Program
3. Medical College of Wisconsin  
*See list under Children's*
4. Aurora Midwifery & Wellness Center
5. LifeTime OB/GYN
6. Westside Health Association  
*See sites under CommunityConnect*
7. Kenosha Community Health Center  
4536 22<sup>nd</sup> Ave  
Kenosha

## High Risk Obstetric Medical Home Pilot Implementation Plan

### The Medical Home Pilot

CommunityConnect Healthplan (CCH) is committed to working in partnership with the state and key providers in the community to design and implement a new medical home pilot for pregnant women who are at risk for having a poor birth outcome. The goals of our proposed medical home pilot are to:

1. Provide high-risk pregnant women with enhanced access to comprehensive care that addresses an individual's entire health and social support needs;
2. Address the psycho-social and social support needs of high-risk pregnant women through effective care management and linkages to community-based resources and services;
3. Promote the use of and adherence to evidence-based clinical guidelines;
4. Ensure continuity and coordination of care among multiple providers who are involved in an individual's care;
5. Provide resources and tools to medical home providers in order to support the provider-patient relationship;
6. Enhance the involvement of consumers in their care, promote self-care management and health promotion and prevention; and
7. Optimize care, improve outcomes and reduce unnecessary health care costs.

### Medical Home Strategy Highlights

- We will improve birth outcomes with Sixteenth Street Community Health Center, two Aurora Health Care clinics, Wheaton Franciscan St. Josephs Hospital Women's Health Center, and West Side Health Care Clinic.
- We will ensure care coordination services at Medical Home sites by employing a CCH case coordinator, providing on-site and other outreach staff to medical home sites, integrating high risk obstetric and behavioral health program care managers into the medical home clinical team, adding provider and member incentives, developing comprehensive care plans, and using registry data to optimize clinical intervention and social supports.
- We will actively recruit members and retain them through an innovative Centering Pregnancy model and Centering Parenting group visit model.
- Bruce Kruger, based in Milwaukee, Wisconsin is the executive sponsor of the medical home pilot. Subject matter expertise will be provided by Harvinder Sareen, PhD, based in Camarillo, California.

CCH will establish a CCH Medical Home Advisory Committee for its medical home pilot with key representation from medical home sites, community and physician leaders, community-based organizations, academia, state and local departments, and high-risk pregnant members to generate buy-in, solicit guidance, stay informed on best practices and challenges, and keep CCH's medical home efforts connected at all times to the people and issues they address.

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## Clinic Partnership

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CCH's strategy for the medical home pilot is to establish relationships with three community health centers that have credibility in the communities of southeastern Wisconsin. CCH has successfully solicited the partnership of the following health care provider organizations:

- Sixteenth Street Community Health Center
- Aurora Health Care Center
- Aurora Midwifery and Wellness Center
- Wheaton Franciscan St. Josephs Hospital Women's Health Center
- West Side Health Care Clinic

These health centers are well positioned to serve as medical home pilot sites for high-risk pregnant women. They have a long history and in-depth experience serving the diverse communities of Southeastern Wisconsin, provide a comprehensive range of services, are staffed by diverse professionals, and are strong advocates for public health issues. Sixteenth Street and West Side Health Care Clinic are federally qualified health centers (FQHC) that have been providing quality health care, health education and social services to low-income Milwaukee residents since 1969. Established in 1984, Aurora Health Care has become a nationally recognized leader in efforts to improve health care quality. Aurora has sites in more than 90 communities throughout eastern Wisconsin, including 13 hospitals, more than 140 clinics and over 80 community pharmacies. In partnership with the UW Medical School, Aurora operates community clinics in the Milwaukee area, most of them in under-served neighborhoods. The Aurora Health Care Center emphasizes prevention and wellness while providing a wide range of primary care. Aurora's community outreach efforts also include an extensive parish nursing program.

Wheaton Franciscan Health Services St. Joseph's Hospital has been a long standing service provider to the inner city of Milwaukee and has a long tradition of care for those in greatest need. The Women's Health Center program has evolved into a comprehensive OB service that has social services, integration with emergency department services and various incentives for patients to establish and continue prenatal and post partum care. They work closely with multiple free and community clinics in their service area.

These organizations have already established some of the capabilities required for a medical home and demonstrate interest and readiness toward becoming a fully developed medical home. For instance, Sixteenth Street has implemented patient care teams, open access scheduling, and same day/next day scheduling. Additionally, the clinic has an on-site WIC clinic, social services, behavioral health, HIV/AIDS outreach and case management, bilingual services, and a partnership with Columbia St. Mary's Hospital and use of their residency program to provide substantial hospital support for low-income pregnant women. They also have an Urgent Care Clinic that operates during evening and weekend hours. West Side Health Care has begun developing an infrastructure to facilitate transition to an accredited medical home and is modifying its scheduling and care management processes to achieve NCQA accreditation.

Moreover, these organizations have demonstrated success with their prenatal and postpartum programs. In 2008, 1,728 women received prenatal care at Sixteenth Street and 893 deliveries were

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performed by the Center's providers. Sixty-nine percent of these deliveries were by the Certified Nurse Midwives in the Center's women's health department. Ninety-four percent of these babies were at or above normal birth weight.

Lastly, as we move forward with the development of the medical home pilot program for high-risk pregnant women, we will also explore the option of expanding the target population to include other CCH members with chronic illnesses. We know for a medical home program to be sustainable at a provider practice level that it cannot be designed for just a small subset of a practice's patients nor just focused on a single payer. To that end, as we move forward we will also explore the potential interest of other payers at the medical home sites to partner on medical home strategies and activities for high-risk pregnant women that may result in increased cost efficiencies for clinic, eliminating the need for the clinic to vary its processes and procedures by payer and sub-populations.

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#### Member Outreach

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##### *Member Outreach, Education, and Identification*

We will implement effective member outreach and education strategies aimed at increasing the awareness of the availability of the medical home pilot program for targeted pregnant women. Program promotional materials, appropriate in terms of literacy level, language and culture, will be disseminated in a manner that leverages both formal and informal communication channels described below:

1. Materials will be posted on the CCH member-friendly website, and on social networking web-sites, and will be distributed to all female members of childbearing age in the target zip codes, distributed in member newsletter, and included in the member handbook.
2. Members will be informed about the medical home pilot by member services staff during new member welcome/orientation calls and other regular contacts, and by community health workers and resource coordinator staff.
3. Home-based outreach will serve as another venue to increase awareness of the availability of the medical home pilot program. CCH has contracted exclusively with Community Advocates to facilitate home-based outreach for its members (Appendix 1).
4. Promotional program materials will also be disseminated for members to pick up in offices of selected community partners, e.g., WIC offices, Planned Parenthood clinics, health departments and other community based organizations serving the target population.
5. Promotional program posters with key messages will be placed at strategic community locations and physician offices. CCH has developed *draft* posters for the medical home pilot. If approved by DHS, unbranded versions of the posters can be leveraged by all HMOs and placed in key locations within designated zip codes (Appendix 2).

##### Targeted Identification and Recruitment of High-Risk Pregnant Women

1. **Healthy Birth Outcomes (HBO) High-Risk Registry.** CCH members that are listed on the HBO high-risk registry will be contacted by our member services staff to explain the medical home pilot program and describe the benefits/program components available to them. The HBO registry will be built from the ground up. This registry will be compiled

by collecting information on non-members eligible for program enrollment, and will be continuously updated as members are identified and enrolled in the medical home. CCH has collaborated with the other HMOs to develop the critical data elements to populate the registry and has additionally worked with them to reduce confusion, redundancy and unnecessary administrative processes in implementing the registry (Appendix 3A, 3B).

2. **High-Risk Pregnancy Screening.** Pregnant members enrolled in CCH's "Future Moms Program" who are screened and determined to be at high-risk for poor birth outcomes and enrolled in the Future Moms High Risk Obstetric (HROB) Case Management program (Appendix 4).
3. **State Membership Files with Pregnancy Indicator.** CCH will review the member eligibility files received from the state on a monthly basis to identify all new members who are pregnant. Members will then be contacted and assessed for program eligibility. Early identification and health risk assessment are critical factors in achieving the key outcomes for the pilot. Utilizing Community Advocates outreach staff coordinated with the Future Moms HROB case management, the goal is to establish care relationships as quickly as possible to assure comprehensive prenatal care services.
4. **The State's High-Risk Pregnancy Report.** Provided by the WI Department of Health Services on a monthly basis, this report will be used to identify women who had a poor birth outcome while receiving BadgerCare Plus. CCH will proactively outreach to these members and assess their eligibility for program services.
5. **Predictive Modeling Tools (Symmetry and Med-AI).** CCH will leverage its predictive modeling capabilities using Symmetry and MedAI predictive modeling tools, using pharmacy and medical claims to identify high-risk pregnant women, especially those with chronic illnesses.
6. **Pharmacy Data** (including 17-P utilization reports). CCH will review pharmacy data reports on a monthly basis to proactively identify pregnant women who may be at risk for a poor birth outcome.
7. **Other Disease Management/Chronic Disease Programs.** CCH will mine data of members enrolled in other programs, such as those for asthma, diabetes and obesity prevention to determine eligibility for the high-risk OB medical home.
8. **Health Risk Assessments.** Assessments which include questions on pregnancy, pregnancy related care, and the existence of chronic conditions and behavioral health issues.
9. **Notification of Pregnancy (NOP).** The NOP is a comprehensive risk assessment that has been associated with improving birth outcomes for women enrolled in Medicaid. It includes questions about maternal and obstetrical history, mental health, substance abuse, and social risk factors. CCH will use this information to identify and address risk factors, and ultimately, to improve birth outcomes.

Effective January 1, 2011, Medical Home providers that complete and submit the NOP by fax to CCH will be eligible for a financial incentive of \$25. To be eligible for reimbursement: a) The pregnant woman must be enrolled with CCH; b) The woman's pregnancy must be within 20 weeks gestation; c) The NOP must be submitted no later than 7 calendar days from the date the risk assessment was completed. Incentive-based

NOPs in other states have demonstrated increased volume of pregnancy notifications thereby significantly increasing our ability to facilitate the early identification of high-risk pregnant members and their early entry into prenatal care (Appendix 5).

10. **Member Prenatal Visit Incentive:** A new member prenatal reward will be given to members who receive a prenatal exam within 42 days of being enrolled into the health plan.
11. **Member Postpartum Incentive:** A postpartum visit reward will be given to members identified as completing their postpartum visit within 21-56 days after delivery.

#### *Community Partnerships and Referrals*

We will collaborate with state, county and local partners to extend our reach and leverage a communication campaign to generate awareness of the availability of the medical home pilot program. We will employ the following strategies to increase awareness of the medical home pilot and identify potential pregnant women who may be eligible for participation in the pilot. Information on all eligible referrals will be shared with our single point of contact – the case coordinator – for further follow up and medical home participation.

1. **Pilot Medical Home Site Internal Referrals.** We will leverage all staff members to promote the pilot and ensure that there are no missed opportunities at various touch points while delivering care to families, grandparents, neighbors and friends of potential participants.
2. **Physician Referrals.** We will educate our contracted provider network on the availability of the medical home pilot program for high-risk pregnant women through a variety of mechanisms that include provider orientations and trainings, provider outreach by Community Advocates staff, provider newsletters, and the provider administrative manual. Physician contracting and communications will include information that will explain in detail the medical home criteria and how to refer a patient for participation.
3. **PNCC (Prenatal Care Coordinator) Referrals.** These referrals will be provided for the identification of high-risk prenatal members, in particular those with chronic conditions. Extensive outreach to PNCC providers will occur and will include a Memorandum of Understanding (MOU) to facilitate awareness and improved access and care pathways. CCH will mine data to identify members and assess their eligibility for the program. The case coordinator will be notified about potential eligible members for further follow-up.
4. **Customer Care Center Referrals.** These include referrals from our customer care and 24/7 Nurse Advice Line. All referrals will be forwarded to the case coordinator.
5. **Outreach Worker Referrals.** We will utilize outreach workers such as Community Advocates and vendors such as Alere, to additionally identify members who may be eligible for participation in the medical home pilot. The case coordinator will be notified about eligible members. Community Advocates will provide free home test kit pregnancy testing to facilitate early detection and referral for obstetrical services.
6. **Community Organization Referrals.** We will outreach to key community-based organizations that provide services to low income pregnant women to establish formal

linkages and referral processes for women who may be suitable for participation in the medical home pilot program.

#### *Medical Home Communication to Member*

Members identified through strategies outlined above will be actively followed-up with to confirm high-risk pregnancies and will be recruited if appropriate for the medical home pilot. Members will be contacted by phone (or in person if indicated) to confirm that they meet the target population criteria for the medical home pilot, and an initial appointment will be made for potential participants.

Each member enrolled into the medical home pilot will be assigned a primary care provider or “OB care provider.” The OB care provider will be responsible for providing the first point of contact care and coordinating the entire continuum of care and services.

Consumer-centered care planning - active engagement of patients in their care and strengthening and supporting the patient-provider relationship will be key goals of the medical home pilot. To facilitate this, the medical home will include the following at pilot sites:

1. Clear and effective communication on the medical home with the high-risk pregnant members, especially around the adoption of standards for patient access and communication. The medical home will entail discussions between the personal physician and patient on the roles and expectations for the medical home and an introduction to all team members. This is also critical in Southeastern Wisconsin where building trust relationships will help lay the foundation for increased compliance with care plans and the likelihood of positive outcomes.
2. Patient-provider contract - patients will be strongly encouraged to fill out a contract pertaining to the medical home and make specific commitments, including but not limited to, keeping all prenatal care appointments (minimum of 10 visits) and keeping the medical home informed about receipt of care outside the medical home. The patient-provider contract has been shown to contribute to the success of the medical home - inculcating patient accountability, establishing trust in the patient-provider relationship, increasing compliance, and improving monitoring of care.

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#### **Member Retention**

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CCH will employ the following strategies to retain members within the medical home:

1. Work in close collaboration with our medical home partner providers and Community Advocates to ensure continuous member enrollment and attendance of prenatal and postpartum visits;
2. Leverage care coordination to provide access to needed services in a timely manner; and
3. Implement programs that have both particularly high patient satisfaction and better outcomes than traditional care to minimize member attrition from the medical home pilot.

Research on birth outcomes has shown early entry into prenatal care is critical to healthy maternal and infant outcomes. As required by the contract, we will make every effort to identify and enroll high-risk pregnant women into the pilot within the first 20 weeks of their pregnancy. In addition, per ACOG recommended prenatal care visit guidelines, our care coordination staff will also work in

collaboration with our medical home partner providers and Community Advocates to ensure the member keeps all prenatal care appointments (minimum of 10 visits) during her pregnancy and is continuously enrolled in the medical home pilot through at least 60 days postpartum.

We will additionally leverage care coordination to assist the member in accessing the services they need in a timely manner given that the current system of care is uncoordinated and fragmented, which creates challenges to find services and keep appointments. Our care coordination model is holistic in nature and takes into account a member's entire health care needs - medical, social, behavioral and environmental. The goals of our care coordination services that will be part of the medical home models are to: ensure access to optimal and appropriate care and services; minimize attrition, promote self-care management, improve systems of care for high-risk pregnant women; improve and sustain maternal and infant quality of life; and optimize birth outcomes.

In addition, we will work in close partnership with our medical home providers to develop effective patient engagement strategies and self care management programs that address the management of chronic illnesses and support healthy birth outcomes. Programs that have both particularly high patient satisfaction and better outcomes than traditional care will be implemented to minimize member disenrollment and attrition from the medical home pilot.

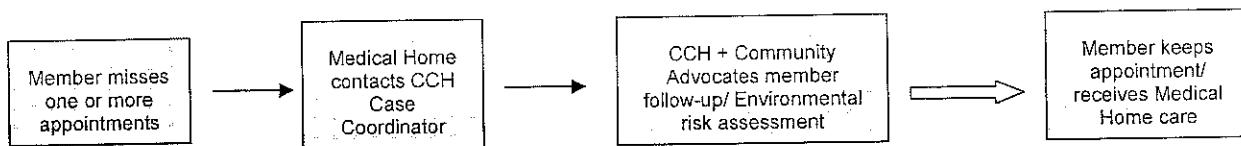
#### *Ensuring Members Keep Appointments*

CCH will work closely with the medical home to ensure that members keep and attend appointments. Appointments for prenatal and postpartum care and appointment reminders will be facilitated by the medical home.

CCH's care coordination services will be designed to enhance the roles of care managers employed by the medical homes. CCH's care managers will help members navigate complex systems and gain access to additional needed programs and services and make appointments. Members who miss prenatal and/or other appointments will be followed up by CCH's case coordinator and care management services. Home-based outreach will be provided by Community Advocates and will be non clinical in nature but focused on reducing or removing barriers to keeping appointments i.e. child care, transportation, etc.

The following procedures will be put into place to follow-up on members who miss one or more appointment(s):

- Medical home contacts CCH case coordinator.
- Case coordinator works with Community Advocates Outreach staff to contact medical home member and develop collaborative plans to establish appointments and encourage ongoing pilot participation. The CA outreach will also incorporate environmental risk assessment factors that may be contributing to interrupted care.
- Communication between outreach staff, case coordinator and medical home care management will be a critical part of maximizing patient continuation in the pilot and their care plan.



### *Encouraging Members to Follow a Treatment Plan throughout their Pregnancy*

Active consumer engagement and participation is a key foundational element of the proposed medical home pilot for high-risk pregnant women. We understand the critical role that members play in improving their health outcomes and know that for the medical home pilot to be successful, the member must be an active and engaged partner in the process from the onset.

CCH will leverage care coordination and work closely with medical home sites and Community Advocates to encourage members to follow a treatment plan. We will additionally put the following structures and systems-of-care in place:

**Personal Physician /Physician-Directed Clinical Care:** Each member enrolled into the pilot will be assigned a primary care provider or “OB care provider.” The OB care provider will be responsible for providing the first point of contact care and coordinating the entire continuum of care and services.

In collaboration with a multi-disciplinary care team, the OB-care provider will work in partnership with the high-risk pregnant member to develop and implement an appropriate individual plan of care based upon a comprehensive clinical and health risk assessment.

Active engagement of patients in their care and strengthening and supporting the patient-provider relationship are also key goals of the medical home pilot. To facilitate this, the medical home will include clear and effective communication on the medical home with the high-risk pregnant members and encourage patients to fill out a contract pertaining to the medical home and make specific commitments, including but not limited to, attending all prenatal visits and keeping the medical home informed about receipt of care outside the medical home.

**Case Coordinator:** CCH will employ a Case Coordinator (initially part-time) for the medical home pilot to enhance the role of care managers employed by the medical homes. The Case Coordinator will be based in Milwaukee and will have a non-clinical background, but with experience in systems development, management, and measurement to improve process and outcomes. Other required experience will include the use of patient registries and demonstrated cultural competence. The Case Coordinator will work closely with the health centers’ clinical teams with an emphasis on working with the medical homes’ care managers. The Case Coordinator will provide training and support to ensure that the care managers (CCH Future Moms) are integrated within the clinical team, assist in developing a comprehensive care plan for each patient and use registry data to follow up on members, optimize clinical interventions and social and other supports. They will also coordinate with the Community Advocates outreach efforts to ensure that the continuity of care is not disrupted by external factors.

**Interdisciplinary Care Plan:** A tool that will be used to prioritize clinical and care management interventions is an Interdisciplinary Care Plan that is on a server accessible to the care team to enable coordination of care. Interventions will be comprehensive and will involve several disciplines supporting the woman in identifying and attaining goals related to family planning, quitting smoking, changing behaviors to control chronic conditions as well as more broad life goals that may also affect the health of both the woman and her children, e.g., education, vocation, and housing.

**Data Systems and Actionable Reports:** A patient registry will be used to help identify priority needs for interventions. Based on local capabilities, the Case Coordinator will either manage a central registry to track claims and other relevant data for all high-risk OB patients enrolled in the

pilot, or will work with medical homes to obtain a patient registry, customize data fields and integrate its use into clinic and care management operations. The central registry will provide profiles of high-risk OB patient's medical and pharmacy utilization (with gaps in care) to further support patient care; and these will be provided to sites in their preferred format and distribution mode. These reports will be instrumental in informing the sites about the patient's potential receipt of care outside of the medical home – information that would otherwise be difficult to track. A clinic-based patient registry has the potential to organize and provide relevant clinical information from the patient record, support proactive management of clinical conditions, identify patients at higher risk, support integration of clinical and case management services, and provide the data necessary for evaluating quality of care for the population.

In addition, CCH will support enhanced data linkages across different systems of care, e.g. between Sixteenth Street clinic and St Mary's Hospital to ensure continuous, and comprehensive tracking of high-risk ob patients.

**Future Moms HROB Care Managers:** CCH's Future Moms HROB Care Managers will work closely with The OB care provider and the care team to help ensure support required to optimize the birth outcome. The program provides care management supports tailored to the needs of the member, including support provided by RNs, health trainers, and social workers and referrals to community resources including behavioral health. The HROB RN provides prenatal behavioral health & substance abuse and post- partum depression screenings at initial and follow up assessments. For members identified with behavioral health issues or concerns (current or past), designated HROB social workers and HROB RNs work together with behavioral health care providers and available community resources to ensure that members receive timely and effective psychosocial interventions (Appendix 6).

**Home Based Outreach (Community Advocates):** CCH will leverage home-based outreach through Community Advocates as determined appropriate by the health care provider to help ensure continued engagement in clinical care and social services, as well as to reinforce self-management support. Home-visits will additionally help assess and address member needs related to transportation, etc. further facilitating member adherence to their treatment plans.

#### ***Collaborating with Existing Community Groups and Other Stakeholders***

CCH will assess gaps in services and contract with select programs or service providers to guarantee access to a broad continuum of services. We will assess and address barriers to access and will work diligently to ensure that, to the extent possible, support services are provided at the medical home site.

The Case Coordinator will work in collaboration with the medical homes to ensure access to the following clinical services on site:

1. **Smoking Cessation.** In 2009, a law was passed in Wisconsin that calls for an indoor smoking ban in public places beginning July 5, 2010. In addition, the law sets forth a comprehensive plan for tobacco prevention and control over the next five years to affect both individual attitudes and societal norms. Significant resources have been made available in the State to reduce smoking prevalence. CCH will disseminate smoking cessation information to members and ensure that those in need of smoking cessation services receive appropriate referrals. CCH and the medical home pilots will work closely with the following resources:

- ***First Breath*** is a program that helps pregnant women in Wisconsin quit smoking. The program is coordinated by the Wisconsin Women's Health Foundation in partnership with the State of Wisconsin Division of Public Health, Bureau of Community Health Promotion, and APS Healthcare Inc.
  - ***Wisconsin Tobacco Quit Line*** offers a single access point to tobacco addiction treatment. Managed by the University of Wisconsin Center for Tobacco Research and Intervention (UW-CTRI), it offers a variety of services, including one-on-one telephone counseling.
  - ***Tobacco Addiction Treatment Education and Outreach Program*** provides Wisconsin clinicians and healthcare systems with training and technical assistance on evidence-based, effective tobacco addiction treatment strategies.
2. **Behavioral Health: Substance Abuse and Perinatal and Postpartum Depression Program.** Women who are either pregnant or have just given birth can be at risk for depressive disorders. Likewise, those with substance abuse issues are at high-risk for poor birth outcomes. CCH will work with the medical homes to assist members who are experiencing difficulties with chronic mental health and/or substance abuse disorders through its Behavioral Health Program. The goals of the program are to identify, triage, and enroll women in two distinct but coordinated behavioral health programs: Tiered Behavioral Health Case Management and Maternal Depression Programs. The integration of medical and behavioral health services for these members is essential to their physical and emotional well-being. CCH's Behavioral Health and Maternal Depression Case Managers will work closely with the OB care provider and the care team to assist these members.

All medical home members will be screened for perinatal and postpartum depression. Perinatal depression screening will be facilitated at the time of entry into the medical home – where the member will be within the first 20 weeks of her high-risk pregnancy. Medical home members will be additionally screened for depression at their post-partum visit scheduled within the first 60 days of delivery. Both perinatal and post-partum screening for depression will include the use of Patient Health Questionnaire 2 (PHQ-2) and/or the Patient Health Questionnaire 9 (PHQ-9) to assess the severity and level of depression. Members will be additionally screened for recent history of behavioral health issues and substance/chemical abuse at the time of entry into the medical home.

*Referral Criteria and Process:* Medical home members will be eligible for CCH's Behavioral Health programs if they have a chronic behavioral health disorder such as Schizophrenia, Bipolar, Major Depression, and other chronic mental disorders. Members who have a recent history of substance/chemical abuse treatment and/or use will also be eligible. Identified and eligible members will be referred directly by the care teams to CCH's Behavioral Health Case Management Program which is staffed by licensed clinicians skilled in working with members with mental health and substance abuse difficulties. The Behavioral Health Case manager will assess the severity and level of intervention required base on PHQ-2 and/or PHQ-9 responses as well as past and present experiences with behavioral health and substance abuse treatment and difficulties. The case manager will additionally determine if the member is appropriate for the Maternity Depression Program.

Referral triggers and criteria will be provided to the OB Care Provider and care teams by CCH (Appendix 7).

3. **17-P.** (17-alpha hydroxyprogesterone caproate.) Preterm birth has been identified as one of the leading causes for poor birth outcomes in Southeastern Wisconsin. Preterm birth is one of the leading causes of poor birth outcomes in Southeastern Wisconsin. Not only do preterm infants have increased risk of mortality and morbidity, these deliveries result in billions of dollars in NICU costs each year. CCH proposes a new benefit/approach available to high-risk pregnant members at risk for recurrent preterm birth. It includes the use of 17-P (an injectable form of progesterone) for the prevention of recurrent preterm birth. The evidence indicates a potential decrease in risk of recurrent spontaneous preterm birth by up to one-third with the use of 17-P. However, this intervention appears to be underutilized, largely due to provider lack of knowledge regarding evidence of clinical benefit, as well as the perceived notion that is not covered.

To ensure appropriate and timely utilization of this benefit for our high-risk pregnant members, CCH will help providers arrange for weekly 17-P injections to be administered in their office, or in the members' homes if medically necessary. Our members will not need to visit a hospital for their injections. Working in collaboration with the high-risk member's care provider our medical management team will authorize services of a home care nurse to provide 17-P injections in the member's home when medically necessary.

Given the misconceptions regarding coverage and clinical evidence, we will seize every opportunity to educate providers about 17P, using verbal and written communication. Providers will have the opportunity to participate in webinar training sessions regarding the benefits and use of 17-P, and how to communicate this information to patients. To optimize program use, a provider financial incentive will be implemented for use of 17P in appropriate clinical circumstances.

Members will be educated via verbal and written communications. High-risk members will receive information on 17P from their OB care provider/PCP and the care team during clinic visits. They will also receive written materials explaining its use and benefits. Members will receive phone calls as necessary if they cannot be provided this information during clinic visits.

4. **Nutritional Counseling.** Nutritional counseling provided by a dietitian will be included as *an additional service* provided by the medical home.

The Case Coordinator will ensure medical home referrals to supplemental clinical and social services either on site or in the community:

1. **WIC.** Leverage relationships with local WIC programs for continuity of care and resources. WIC provides home outreach visits, classes, vouchers etc. CCH will replicate best practices from other states by co-locating a plan outreach worker bi-weekly at WIC locations to address patient Medicaid and/or medical home questions or issues. Additionally, we will consider ways of promoting WIC (i.e. gas stations publicizing accepting WIC checks and improving their supplies of WIC-approved items).
2. **Family Planning.** CCH will work in coordination with Planned Parenthood to assist members with family planning services such as birth control, sexual health and women's health. Planned Parenthood is a community leader on topics of women's health, access to

care for women, women's rights, and teen sexual health, to name a few. With 28 locations across Wisconsin, five of those in Milwaukee, CCH members will have the access they need for family planning services.

3. **Life Skills Progression/Healthy Beginnings (LSP/HB).** CCH will utilize the Life Skills Progression/Healthy Beginnings functional health literacy curriculum to empower families by improving the functional health literacy of low income pregnant women and new parents. The program will be integrated into the established home visitation programs serving pregnant women and new parents (described in the section below). CCH will provide the materials and required training.
4. **Safe Sleep Program.** CCH will implement its Safe Sleep Program. The goal of the program is to decrease the incidence of SIDS and sleep-related infant deaths. Through the program, we will provide cribs, education and "Safe Sleep Kits" to families.
5. **Diaper Drive.** Low-income families often struggle with the additional costs associated with their diapers and wipes for their babies. Due to this, a baby may spend an entire day in a single diaper, increasing the risk of health problems. Our local team will replicate a popular program from other states by launching a new two to three month "Diaper Change" initiative to provide the supplies necessary for 250,000 diaper changes to low-income families.
6. **Baby Showers for Pregnant Women.** CCH will replicate another popular program from other states by inviting expectant and new mothers to a Community Baby Shower and solicit a TV news anchor/celebrity (a mother) to host this new event. As in the Diaper Drive, we will solicit the participation of our community-based partners and businesses. The shower provides an opportunity to provide prenatal/early childhood health education emphasizing immunizations, dental care, SIDS prevention, tobacco cessation, car seat safety, early childhood development and nutrition.

The Case Coordinator will ensure appropriate medical home referral to the following enabling services:

1. **Home Visits.** To help ensure linkages and continued engagement in clinical care and social services, as well as to reinforce self-management support, home visits will be conducted by Community Advocates. CCH will supplement prenatal home visits when needed through its contract with Alere Homecare. Alere provides home-based obstetrical services to high-risk women in association with the physician's care plan. CCH will notify Alere of any physicians who are not familiar with Alere and their contracted services to expedite partnerships and processes. Alere will follow-up and establish contact with these physicians and practices to ensure smooth and efficient referral processes for members needing home-based services.
2. **Transportation (MTM).** Lack of transportation continues to be a challenge for Medicaid families in making appointments and complying with care plans. CCH has contracted with MTM, a transportation brokerage firm to address this challenge in Southeastern Wisconsin. MTM in turn subcontracts with a network of providers, thereby simplifying administration and oversight for CCH.

CCH will ensure that MTM subcontracts with the necessary providers and community resources to provide a full range of services as needed for the HROB member population.

This transportation service will be woven into the extensive web of other services provided through the program and will be available by referral from the case management team to members as appropriate. Each member that participates in the medical home will be assessed for transportation needs as part of the overall care planning process. In addition, transportation reports allow us to track receipt of services.

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#### **OB First Contact of Care**

CCH will assign a primary care provider or “OB care provider” to each member that is enrolled into the medical home pilot. The OB care provider will be responsible for providing the first point of contact care and coordinating the entire continuum of care and services.

As elaborated earlier, active engagement of patients in their care and strengthening and supporting the patient-provider relationship are also key goals of the medical home pilot. To facilitate this, the medical home will include clear and effective communication on the medical home with the high-risk pregnant members. The OB care provider will play a key role in providing this information and in completing a patient-provider contract pertaining to the medical home which will include specific commitments made by the patient that include but are not limited to attending all prenatal care visits (minimum of 10 visits) and keeping the medical home informed about receipt of care outside the medical home.

#### *Functioning of the Medical Home Team*

The OB care provider will be responsible for leading a multi-disciplinary care team that will be assigned to each member. This team including the physician, nurse, nurse, midwife, medical assistant, care coordinator, social worker, nutritionist, and others as appropriate, will ensure that the high-risk pregnant member’s clinical and psycho-social needs are met.

In collaboration with the multi-disciplinary care team, the OB-care provider will work in partnership with the high-risk pregnant member to develop and implement an appropriate individual plan of care based upon a comprehensive clinical and health risk assessment.

The team will also include the CCH case coordinator who will work with each of the medical home pilot sites and serve as a primary contact for the CCH medical home pilot and play a role in coordinating care for medical home members. In addition, each medical home site location will be provided the opportunity to have assigned CCH outreach staff available on-site to assist in developing necessary support services, etc. The CCH case coordinator and the CCH Community Advocate outreach staff will serve to enhance the roles and capacities of medical home site care managers.

The primary goal of the CCH medical home pilot is to provide a single point of contact for facilitation of external services and to depend on a single point of contact for assessment and updates of patient conditions and circumstances. It is the goal of CCH to minimize confusion, create easy pathways for communication and to make the function of the medical home as efficient as possible.

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#### **Written Standards for Access and Communication**

The Medical Home will adopt written standards for patient access and communication to the member mutually decided upon by the HMO and medical home sites and approved by DHS. These standards will meet the appointment and waiting times specified in Article III, H of the contract.

*Written Standards for Accessibility of Care Adopted by the Medical Home*

**Prenatal, Postpartum, and Acute Care Appointment Wait Time Standards:** The medical home standards for waiting times for appointments must be as follows for the indicated type of care:

- High Risk Prenatal Care Services - First Prenatal Visit

The Medical Home must provide the first prenatal visit/assessment within 7 days of the medical home member's high risk pregnancy being confirmed and/or enrollment into the medical home.

- High Risk Prenatal Care Services – Additional Prenatal Visits

The Medical Home must provide additional prenatal care visits within 7 days of a request for an appointment by the member or member's advocate (case coordinator, Community Advocates, HROB case managers, etc.); the medical home must allow for a minimum of 10 prenatal care visits or more as required by the medical home member.

- Post Partum Services

The Medical Home must provide post-partum care within 7 days of a request for an appointment by the member or member's advocate (CCH case coordinator, Community Advocates, HROB case managers, etc.); the post-partum visit should be within the first 3- 6 weeks after delivery.

- Acute High Risk Prenatal or Acute Post Partum Care

The Medical Home must provide medically necessary urgent/emergent services through urgent care facility or emergency room as medically necessary (including holidays and weekends).

As sites transform into full medical homes, the waiting times for these appointments is expected to decrease, accompanied by an increase in the number of same day appointments. CCH will work collaboratively with its medical home sites to reinforce or modify waiting times for these appointments for CY 2012 and CY 2013 (year 2 and year 3 of the pilot).

**Availability of Medical Advice 24/7:** Medical Home Sites will have numerous options available to them to be accessed at all times - during normal office hours and after normal office hours. During normal hours, a same day response is expected. A return phone call or e-mail is acceptable. After normal hours care is to be handled in the following manner: 1. have staff available outside of normal hours for appointments or advice; 2. Documented procedure for members to follow (i.e. – posted on office website). 3. Access via other means such as phone or email.

The primary avenue will be through a cell phone or text option to the appropriate staff member. This will allow for almost instant access and allow the member to be triaged as soon as feasible. The email option will allow the member to describe a non-urgent situation in detail so that staff can triage appropriately, such as an ear infection that could be seen first thing in the morning helping avoid an ER visit during the night.

CCH will also provide access to its 24/7 Nurse Advice Line which provides live assistance by a nurse and includes an audio library of educational resources in English and Spanish.

**Same Day Appointments:** As the sites transforms into a full medical home, they must demonstrate an increase in same day appointments. CCH will work with the medical home sites to set standards for CY2011 and CY2012 (year 2 and year 3 of the pilot). Scheduling will be a key part of this effort. The practice will need to ensure a block of appointments is available everyday, in the morning and afternoon, to help accommodate member needs. This will primarily be met by utilizing scheduling software with the capability to block future time periods in advance.

#### ***Member ED Use***

The medical home sites will coordinate with multiple areas to ensure Emergency Room utilization is entered into the member's clinical file. A strong connection with local hospital facilities is a key first step in this process. By working closely with the local hospitals, a relationship will be developed so that hospital staff can engage the medical home site as soon as possible, sometimes even while the member is in the ER waiting for service. This relationship will allow the member to receive care from their OB care provider and care team and allow the ER to focus on more critical cases. The next key step will be to monitor CCH ER usage (as close to real time basis) for pilot members to construct appropriate interventions and provide timely follow up care. Utilization of the current Wisconsin Health Information Exchange will be explored to see what opportunities might exist within the exchange for improved coordination of care. All of this information will be incorporated into the health record so that a complete picture of the member is available and appropriate medical, behavioral and community outreach interventions might utilized.

#### ***Evaluation of the Relationship between Providers and CCH***

CCH will establish a Physician Quality Improvement Committee (PQIC), chaired by the CCH medical director. The PQIC voting members will include primary and specialty physicians from the health plan's local provider network. The "outside physician" committee members will provide valuable clinical input on CCH's quality program, medical policy, peer review/credentialing activities, CCH preventive health and clinical practice guidelines, review of member grievances and appeals, and other CCH quality improvement activities.

CCH in collaboration with designated medical home clinical leaders and clinical representation from the other RFP health plans, will facilitate a Quality Forum to review relevant clinical data, assess care processes, establish and review outcome measures and identify "best practices." The goal of the forum will be to improve birth outcomes for the community and to assert clinical leadership in improving access to quality care and improved quality of care through objective, consensus based measurement.

CCH will establish a CCH Medical Home Advisory Committee for its medical home pilot with key representation from its medical home site providers, community and physician leaders, community-based organizations, academia, state and local departments, and high-risk pregnant members to generate buy-in, solicit guidance, stay informed on best practices and challenges, and keep CCH's medical home efforts connected at all times to the people and issues they address. This will provide an additional venue to build on our relationship with our medical home providers.

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#### **Electronic Health Records**

The medical home sites will use an Electronic Health Records system or registry to manage medical home member data, organize their clinical information including the presence of chronic conditions, track test results, and referrals. The Electronic Health Records system for each practice will vary

based upon their investment in this type of technology. There are a number of different vendors in this market – all offering multiple variations from prescribing modules to patient portals. The higher certification from NCQA generally means that a practice will have an advanced EHR that can provide them a full spectrum of information for each patient. If a practice has not yet invested in an EHR yet, it can still achieve a Level I from NCQA. For this type of practice to achieve a Level III, it would be very difficult until they made the investment in a top tier EHR system.

CCH has made a commitment to facilitate accreditation by NCQA of the FQHC medical home sites throughout the term of the pilot. CCH will provide a comprehensive baseline assessment, develop a plan for the site to achieve an appropriate level of NCQA accreditation, and provide consultative assistance throughout the process.

#### **Implement Evidence-Based Practices**

##### ***Medical Home Adoption of Evidence-Based Guidelines for Chronic Disease and Pregnancy***

CCH will work closely with the medical home sites to ensure, consistent with our existing practice, that OB/PCPs use the current American College of Obstetrics and Gynecology (ACOG) and American Academy of Pediatrics (AAP) Guidelines for Perinatal Care for delivery of care to pregnant members. We will also ensure that OB/PCPs incorporate the State's identified best practice standards for high-risk pregnancy care into their practice.

CCH also uses the Milliman Care Guidelines® to guide implementation of evidence-based care. These guidelines are updated annually.

##### ***CCH Evaluation to Ensure Use of Guidelines***

CCH will operate a quality improvement process that includes education and outreach to providers and members, data collection, analysis and reporting and feedback (including CAHPS, HEDIS®, customized reports and ad-hoc quality initiatives). Systematic feedback will be obtained and provided across all functions and divisions including care management, utilization management, customer service, provider services and analytics. A formal Quality Committee structure will be used to perform root cause analyses, quality improvement planning and other activities including assessing and ensuring use of evidence-based guidelines.

##### ***Procedures for Addressing the Complex Needs of Women with Chronic Conditions***

Uncontrolled chronic conditions may result in poor birth outcomes. CCH will ensure availability of chronic condition management and disease management programs for pregnant and postpartum women with co-morbidities, including chronic conditions. In addition to our Future Moms program, our condition management and DM programs and specialized initiatives include our: Asthma DM Program; Diabetes DM Program; CHF/CAD/COPD program; Chronic Kidney Disease (CKD) program; End Stage Renal Disease (ESRD) program; Emergency Room program; Smoking Cessation programs; and Well Woman and Breastfeeding Education programs.

These programs engage the member's provider in establishing an individual care plan. In the chronic condition management program, case managers provide regular telephonic contact (frequency based on level of risk) to support the member in developing realistic self-management goals, monitoring progress, ensuring adherence to a treatment plan, ensuring appropriate specialty referrals and referrals to other community resources, and assisting members in navigating the

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healthcare system. High-risk members with chronic disease will be offered enrollment in the disease management program.

Medical home members will have available to them CCH's care management program for high risk obstetric (HROB) members – Future Moms Program. Members who are pregnant with chronic conditions are managed by CCH's HROB specialized RN Care Managers during their pregnancy and then referred to Complex Case Management or if applicable to Condition Care Case management programs for follow up after postpartum and beyond.

The HROB Team has bi-weekly Medical MD Case Rounds with CCH's OB Medical Director where the nurses can bring any complex cases including those with co-morbid conditions that could potentially affect their pregnancy outcome to further discuss the most appropriate plan of care with MD oversight.

It is the goal of the CCH pilot program to integrate these program efforts with the medical home providers through the use of the case coordinator to assure that a comprehensive plan of care is shared across all components of the delivery system to coordinate care delivery and maximize positive birth outcomes.

CCH uses the current American College of Obstetrics and Gynecology (ACOG) and American Academy of Pediatrics (AAP) Guidelines for Perinatal Care for delivery of care to pregnant members and the Milliman Care Guidelines<sup>®</sup> to guide implementation of evidence-based care.

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### Patient Self-Management

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#### *Engagement and Education of the Member in Patient Self-Management*

Self-management and active engagement of patients in their care will be a key goal of the medical home pilot. To facilitate this, the medical home will include clear and effective communication on the medical home with the high-risk pregnant members. In addition, patients will be required to fill out a contract pertaining to the medical home and make specific commitments, including but not limited to, attending all prenatal care visits (minimum 10 visits) and keeping the medical home informed about receipt of care outside the medical home. The patient-provider contract has been shown to contribute to the success of the medical home - inculcating patient accountability, establishing trust in the patient-provider relationship, increasing compliance, and improving monitoring of care. Each member will have the benefit of an individual plan of care developed by her OB Care provider and care team.

Members will also benefit from Centering classes at medical home sites (described later) that aim at engaging, encouraging, and empowering members to better manage their high-risk condition(s) and seek appropriate prenatal and post-partum care.

Self-management will also be promoted through CCH's Future Moms HROB care management program which assists members in setting realistic self-management goals based on clinical and individual priorities. Members are engaged through motivational interviewing and care managers comprised of Registered Nurses (RNs), Licensed Clinical Social Workers, and Registered Dietitians to work with them to develop action plans to meet their individual goals. Case managers help implement member-centric care plans that incorporate a member's individual needs as well as the care recommended by their primary doctor and/or specialist. They also help members identify needed health plan services and available community resources and emphasize planning for timely

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preventive care. The ultimate goal of care management is to help the member develop the self-care management skills needed to improve their health status and maintain that level of health.

In addition, home-visits enable high-risk women to conveniently access needed services and engage in management of their condition. CCH has contracted with Community Advocates to provide home-based outreach and with Alere Maternity Services in Southeast Wisconsin to provide in-home services. CCH's HROB program nurses will work closely with physicians and other health care professionals to ensure they understand Alere's role and services, and the program's added value to the member. They will also assist with referral processes for appropriate members who would benefit from home services.

#### *Incentives to Engage Members in Self-Management*

**Member Prenatal Visit Incentive:** A new member prenatal reward will be given to members who receive a prenatal exam within 42 days of being enrolled into the health plan

**Member Postpartum Incentive:** A postpartum visit reward will be given to members identified as completing their postpartum visit within 21-56 days after delivery

#### *Patient Self-management Educational Tools and Materials*

**Centering/Health Education Classes:** Health education classes at medical home sites will aim at engaging, encouraging, and empowering members to better manage their high-risk condition(s) and seek appropriate prenatal and post-partum care. Included will be both Centering Pregnancy and Centering Parenting. The Centering model is on the forefront of system reform, provides care that is culturally appropriate and emphasizes self-management and patient empowerment.

In *Centering Pregnancy*, eight to twelve women with similar stages of gestation meet together for a total of ten sessions throughout pregnancy and early postpartum. Each two-hour prenatal care session includes physical assessment, education and skills building, and support through facilitated group discussion. Centering Pregnancy groups provide a dynamic atmosphere for learning and sharing that is impossible to create in a one-to-one encounter, which contributes to engagement in prenatal care. The groups provide support to the members and also increase individual motivation to learn and change.

Scientific studies on Centering Pregnancy indicate improved outcomes for pregnancies, specifically increased gestational age and birth weight of preterm deliveries. Evaluative data consistently confirms that 96-97% of all women in the groups preferred getting their care in this way. Providers also report personal satisfaction as they get to know the women much better during the 20 hours of contact time versus approximately 2-3 hours they might have during traditional care.

Improved birth spacing, control of chronic conditions and other interventions during the interconceptional period are critical to ensure improved birth outcomes for the subsequent pregnancy. Women typically do not seek health care for themselves during the interconceptional period; they are much more likely to seek health care for their babies. *Centering Parenting* is a group visit model that builds on Centering Pregnancy. Centering Parenting is focused both on the mother and the baby. Evidence-based interventions to improve birth outcomes for the next pregnancy during the interconceptional period are incorporated into this group visit model. Core content revolves around the three major areas of health, safety, and development with mother/baby/family attachment as a thread throughout. It involves providing all of the standard

well-baby care including immunizations, developmental assessment, and standard interconceptional care including depression screening, contraceptive counseling/care, weight/diet management and general health monitoring. The standard protocol has groups of 5-6 women meeting together approximately ten times during the first year at 2,4,6,8 weeks and 3,4,5,6,9 and 12 months. Through the group visit series, women get to know each other, build community, and gain confidence in their own knowledge and skills. Self-care activities contribute to their understanding of themselves, their babies and their sense of confidence in their decision-making abilities.

**Life Skills Progression/Healthy Beginnings (LSP/HB):** CCH will utilize the Life Skills Progression/Healthy Beginnings functional health literacy curriculum to empower families by improving the functional health literacy of low income pregnant women and new parents. The program will be integrated into the established home visitation programs serving pregnant women and new parents through Community Advocates. CCH will provide the materials and required training.

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#### Measuring Practice, Physicians, and Reporting

##### *Assessment of the Medical Home*

CCH's measurement/assessment of the Medical Home and individual physicians will be guided by the following criteria:

- Technology
- HEDIS (Healthcare Effectiveness Data and Information Set ): Clinical measures including prenatal and postpartum care and frequency of ongoing prenatal care
- Clinical measures: prenatal and postpartum care HEDIS measures, frequency of ongoing prenatal care HEDIS measure
- CAHPS – consumer assessment survey CAHPS (Consumer Assessment of Healthcare Providers and Systems): Consumer assessment survey
- Other measures including HEDIS-like measures e.g. Wisconsin Collaborative for Health Quality (WCHQ) Wisconsin Primary Health Care Association measures
- Performance Reports (practice and individual physicians) Performance Reports (practice and individual physician level data)
- Demonstrated cultural competency among provider and office staff

Our Quality Improvement nurses will work closely with clinical teams to facilitate continuous quality improvement and assist with data tracking and reporting. Physician practice performance will be tracked with respect to the provision of clinical services, patient outcomes and patient safety in accordance with the standards established by the National Committee for Quality Assurance (NCQA).

CCH will collect HEDIS data on prenatal and postpartum care and frequency of ongoing prenatal care for members to measure the Medical Home.

We will additionally assess member satisfaction through the following CAHPS measures:

1. Overall rating measures (adult and child):
  - Health plan
  - Personal doctor

- Specialists
  - Health care
2. Composite measures (adult and child):
    - Health plan
      - Customer service
    - Health care
      - Getting needed care
      - Getting care quickly
  3. Personal doctor and specialist (adult and child):
    - How well doctors communicate
    - Shared decision making

The above measures capture the key aspects of the patient-centered medical home practice: member satisfaction technology, and measurable performance. Since the member is literally at the center of these newly transformed practices, it will put the emphasis on their entire overall health – not just the actual office visit. By addressing all of the member's needs within the medical home setting, it allows the member to feel the provider is truly coordinating all aspects of their care. The technology is one of the tools to allow this to happen. Lastly, by utilizing measures that can be captured and reported, the medical home sites can identify issues and trends much faster for the member and the entire practice.

#### *Reporting Measures to the Medical Home, Physicians, and Members*

CCH will provide the medical home and our physician partners with gaps-in-care reports, HEDIS results for the group and other important clinical information that would be useful to them. Reports to clinic leadership and clinical teams will be provided in aggregate for each of the pilot medical homes, and individual provider profiling reports will be directed toward the individual provider.

CCH will report to members of the medical home on the quality of the performance of the medical home/physician practice and of individual physicians.

#### *CCH Experience and Capacity to Run these Quality Measures*

WellPoint operates a quality improvement process that includes education and outreach to providers and members, data collection, analysis and reporting and feedback (including CAHPS, HEDIS®, customized reports and ad-hoc quality initiatives.) Systematic feedback is obtained and provided across all functions and divisions including care management, utilization management, customer service, provider services and analytics. A formal Quality Committee structure is used to perform root cause analyses, quality improvement planning and other activities.

We report HEDIS performance measures across our lines of business and for our Medicaid and SCHIP plans in accordance with NCQA requirements. HEDIS data is utilized at a health plan level to identify areas for systemic improvements that may involve the health plan infrastructure, network, and our community partners. At the provider group level, the outcomes assist us in developing physician initiatives to impact priority improvements. Adherence to the preventive care and clinical practice guidelines are monitored at the provider group and are used to address sub-optimal performance and to develop pay for performance incentives.

We also utilize HEDIS measures to monitor and report on performance trends over time, track variations in patterns of care and provide recommendations for future quality improvement, in

accordance with the standards established by the National Committee for Quality Assurance (NCQA). We provide our physicians with gaps-in-care reports, HEDIS results for the group and other important clinical information useful to our providers.

Our prenatal and HROB programs collect HEDIS data on Prenatal and Postpartum care.

WellPoint conducts CAHPS across all of our health plans in accordance with each health plan's contractual requirements specific to a state. CAHPS measures collected for our Medicaid health plans that assess consumer satisfaction include:

1. Overall rating measures (adult and child):
  - o Health plan
  - o Personal doctor
  - o Specialists
  - o Health care
2. Composite measures (adult and child):
  - o Health plan
    - Customer service
  - o Health care
    - Getting needed care
    - Getting care quickly
3. Personal doctor and specialist (adult and child):
  - o How well doctors communicate
  - o Shared decision making

The CAHPS are fielded annually and results provided to the CAHPS Quality Improvement team.

Our CAHPS Quality Improvement team, which includes senior operational staff from all our departments (QI, health services, utilization management, communications, customer service operations, Community Resource Centers, field operations, and provider contract data administration) meets as soon as the data is available and fully analyze our results. The CAHPS team conducts a barrier analysis, identifies the areas of greatest concern and identifies interventions needed to improve member receipt of care and satisfaction in targeted areas. State-by-state, strengths and opportunities are identified. The CAHPS team makes recommendations for prioritizing the focus areas for improvement. The recommendations are presented at the Quality Interventions Strategy Committee meeting, and for final approval at the Physicians Quality Improvement Committee. Based on results of the survey the CAHPS Survey work group develops and initiates quality improvement plans, makes and receives committee recommendations for interventions, and provides periodic updates on the success of selected interventions as needed.

WellPoint health plans routinely develop performance reports that include qualitative and quantitative analyses, including analysis of processes, quality data findings and utilization.

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### Cultural Competency

Our Cultural and Linguistics Program functions are integrated throughout the organization, including in our Customer Care Center and our Community Resource Center, to ensure that the entire organization is aware of and working towards cultural competency. This program provides members, and our front-line staff, with appropriate tools to ensure effective communication.

We also ensure that our members receive information that is culturally optimized. Translation of member materials is done by professional certified translators who have had formal education in their target language with the ability to read and understand the source language. These translators also have the experience with the culture of the target language and a background in healthcare and managed care. We also use certified translation professionals who are capable of conducting back translations as deemed necessary and upon request.

CCH will also provide its nationally recognized toolkit on cultural competency to medical home providers. "Caring for Diverse Population: Better Communications, Better Care" is an electronic toolkit with tips and tools for the physician office on cross-cultural community skills, use of interpreters, and other key elements to communicate in culturally diverse area. CCH staff will participate in the pilot sites cultural competency training and will be integrated, where appropriate, into various diversity, privacy and other in-service training sessions.

This set of materials was produced by a team of health care professionals from across the country dedicated to providing quality, effective, and compassionate care to their patients. Because of changes in demography, in our awareness of differences in individual belief and behavior, and new legal mandates, we are continuously presented with new challenges in our attempts to deliver access to health care to a diverse patient population. This toolkit was developed to provide resources to help address the very specific operational needs that often arise in a busy practice because of the changing service requirements and legal mandates. The toolkit contents are organized into several sections, each containing helpful background information and tools that can be reproduced and used as needed. Below is a list of the section topics and a small sample of their contents.

*Resources To Assist With A Diverse Patient Population Base:* Encounter tips for providers and their clinical staff, a mnemonic to assist with patient interviews, help in identifying literacy problems, and an interview guide for hiring clinical staff who have an awareness of cultural competency issues.

*Resources To Communicate Across Language Barriers:* Tips for locating and working with interpreters, common signs and common sentences in many languages, language identification flashcards, and language skill self-assessment tools.

*Resources to Increase Awareness of Cultural Background And Its Impact on Health Care Delivery:* Tips for talking with a wide range of people across cultures about a variety of culturally sensitive topics, and information about health care beliefs of different cultural backgrounds.

*Regulations and Standards for Cultural and Linguistic Services:* Linguistically Appropriate Service (CLAS) Standards," which serve as a guide on how to meet these requirements.

*Resources for Cultural and Linguistic Services:* A bibliography of print and internet resources for conducting an assessment of the cultural and linguistic needs of a practice's patient population, staff and physician cultural and linguistic competency training resources - plus links to additional tools in multiple languages and/or written for limited English proficiency. This toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort (ICE) Cultural and Linguistics Workgroup, a "volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies and accrediting bodies working collaboratively to improve health care regulatory compliance through education of the public." More information on the ICE Workgroup may be obtained at their website: [www.iceforhealth.org](http://www.iceforhealth.org)

### *Interpreter Services*

Members will be able to access needed interpreter services through the medical home. Additional interpreter services will be available through CCH.

### *Cultural Competency Training, Policies, and Procedures in the Medical Home Clinic*

CCH will work with our pilot sites to assure that training programs are available and adequately resourced, that policies and procedures are available and consistent with the JCAHO accreditation standards for outpatient facilities.

The selected pilot sites all have the unique characteristics of service to diverse populations and have developed significant programs to improve provider and support staff awareness of cultural diversity. CCH will work closely with the sites to assure ongoing assessment and improvement in site cultural competency.

### *Use of Existing Groups to Promote Cultural Competency in the Medical Home*

We will implement Centering Pregnancy and Centering Parenting in the medical home. Centering groups provide a dynamic culturally optimized atmosphere for learning and sharing that is impossible to create in a one-to-one encounter, which contributes to engagement in care. The groups provide support to the members and also increase individual motivation to learn and change.

CCH will leverage local consultants at the University of Wisconsin to facilitate training in both Centering Pregnancy and Centering Parenting. The participating medical home sites have expressed strong interest in these programs; one has begun a pilot in the Centering Pregnancy model. The Centering model is on the forefront of system reform, provides care that is culturally appropriate and emphasizes self-management and patient empowerment.

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### **Case Coordinator**

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#### *Case Coordinator Qualifications, Activities and Expectations*

CCH will bring a case coordinator on board who will serve as a single point of contact for the medical home pilot. The coordinator will assist in tracking member participation in the medical home pilot, member progress on the care plan, including regular communication with the care team, contact providers and community based services as and when needed to facilitate access, and assist with other implementation-related duties for the Medical Home Pilot. The more structured duties of the case coordinator during each stage of the pregnancy are being defined collaboratively with our medical home partners.

The job description for the case coordinator will be as follows: Responsible for developing, implementing and managing a business plan to partner with other resources in providing services that improve the health of members in a particular segment of the business. Primary duties may include, but are not limited to: Establishes and maintains strong partnerships with the various workgroups and committees and serves as point person for community liaisons to plan and implement high risk OB programming and services. Develops and maintains strong relationships with pilot program providers, referral network providers and members and serves as a single point of contact for various community liaisons to optimally coordinate service delivery. Interfaces with both internal and external resources regarding policy, program integrity, program enhancement, and improved program performance.

Monitor activities to ensure program objectives are met within established time frames and budgets. Additional responsibilities include; scheduling, conducting and attending meetings, supporting management in overall objectives, assessing costs and savings and assist in the payments of vendor invoices. Compiles complex data, reporting and is able to assist in preparing and delivering presentations as required. Develops a comprehensive understanding of health plan programs and assists in developing training, outreach and provider and member awareness, working with a wide range of stakeholders. Maintains contact with and knowledge of the relevant issues in areas applicable to the business segment. Resolves access and cultural sensitivity issues identified by staff, providers, and community organizations and develops outreach and training activities related to those identified issues. Must have a bachelor's degree in social work, public health, public policy or related field. Master's degree preferred. Experience with care coordination, and maternal and obstetric populations preferred.

#### *Patient Advocacy Activities*

One of the most important roles for the Case Coordinator to fill is as a patient advocate. While the member will take on more responsibility in a patient-centered medical home, the practice and the Case Coordinator must advocate for the member in many different areas. As an advocate for the member, the Case Coordinator will work with different providers and community based services to ensure the administrative and clinical aspect of their care is handled in a proactive manner so the continuum of care is not interrupted. The Case Coordinator will also advocate for the member to the family and other caregivers especially so that all involved will understand and support the member in the quest back to health. Community Advocates staff will also work closely with the case coordinator and the pilot sites to provide feedback and, when appropriate, advocacy, to assure that impediments to care are minimized.

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#### Discharge Plan

##### *At Discharge*

The new mother needs support and reassurance during the postpartum period to instill a sense of confidence and to encourage a healthy mother-infant relationship. Consistency of the information provided to the new mother by the hospital staff can assist with this confidence.

Per standard of care, the discharging physician will instruct the new mother on expected postpartum changes and signs of possible complications. The new mother will be instructed to call her medical home if she has questions or concerns. She will also be instructed on the timing and the importance of the post-partum visit and given referrals to support services such as La Leche League and Planned Parenthood.

*Contraception:* Many women resume sexual relations prior to their postpartum office visit. Therefore, it is important to address contraceptive options prior to that visit. Following standard of care, upon discharge, the discharging physician will address both contraceptive options and risk of shortened interpregnancy interval. The new mother will be advised to initiate contraception well before the postpartum visit and prior to the resumption of sexual activity.

If the new mother is undecided or declines contraception at the time of discharge, contraceptive options will again be addressed during the post-discharge call, as well as during the post-partum visit, as described below.

#### ***Post-Partum Activities (first 60 days)***

As specified in the contract, if the member has a healthy birth outcome, she shall be enrolled in the Medical Home pilot for 60 days post-partum. If the member had a poor birth-outcome as defined by the Department, she will continue to be enrolled in the Medical Home pilot.

The Case Coordinator will stay apprised of the treatment plans for the infant and the mother developed by the OB care provider with input from the mother, including needed appointments with other providers who are appropriate to provide ongoing services for the mother and infant's specific needs. After the initial appointments have taken place and the 60 days post-partum is complete, the mother's enrollment in the Medical Home will cease.

**Post-Discharge Call:** CCH will use its Post-Discharge Call program to follow up with the new mother after being discharged from the hospital. Leveraging real time data/information on the member's date of delivery, post-discharge calls will be made within 3-4 weeks post delivery in order to ensure that the member's post-hospitalizations needs are met (including family planning/contraception options). Actions will include but not be limited to ensuring that the member has made a post-partum appointment, reinforcing the importance of the post-partum visit with the OB care provider/PCP and assessing whether the member may need additional supports such as transportation assistance to in order to keep her appointment.

**Home Visits:** Community Advocates will follow up on members who are difficult to reach and/or miss their post-partum appointment.

**Post-Partum Appointment:** Medical home members will have a post-partum visit within 60 days of delivery. At this visit, the provider will assess the new mother's adjustment to life with the new infant and address topics such as the health of the infant, difficulties with breastfeeding, return to sexual activity, contraceptive plan, plans for future pregnancy, risk of shortened interpregnancy interval, and interconceptional care. In addition to these, the post-partum visit will provide an opportunity to facilitate early screening for the new mother's mood and/or post-partum depression. Members screened as at risk for depression can be referred to CCH's Behavioral Health Program. This component is designed to decrease the severity and length of depressive illness through early screening and to improve service coordination, so that mothers-to-be and new moms can experience an increased quality of mood and of life. The OB care provider will remain responsible for medical support services to the member. For those in the Future Moms program, the HROB case managers will collaborate with the OB care provider and CCH behavioral health specialists to ensure coordination between behavioral health and medical services.

#### ***Transition of Member's Care to PCP***

CCH recognizes the importance of continuity of care for both the newborn and the mother. After the member's 60 days post-partum in the Medical Home is complete, the Case Coordinator shall contact the member's PCP to inform him or her of the birth outcome and any concerns that the OB-care provider has regarding the member's health post-partum. As required by the contract, the Case Coordinator shall also educate the member on inter-conception care specific to her needs. The Case Coordinator will follow-up with the mother at least twice a year for two years following the birth to ensure the mother and child are receiving the appropriate care.

CCH will also support the transition of the infant to a primary care physician that may involve a pediatrician or a pediatric sub specialist. Where possible maternal and infant care will be continued in the medical home, but in circumstances requiring specialized care or where there are particular

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geographic considerations CCH's access to care resources will be used to place the member in the best-fit care environment for their needs.

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#### Reporting to DHS

As required by the contract, CCH will submit to the Department by September 15, 2010 a detailed plan on how it will implement the medical home pilot model by January 1, 2011. The plan will address all of the required elements specified in the contract as well as reflect the proposal submitted as part of the RFP bidding process.

CCH will also submit a report to the Department semi-annually—one December 1 and one as part of the HMO's Annual Performance Report due June 1—evaluating its medical home pilot. The report shall include:

1. A list of OB-Care providers participating and which members are assigned to each OB-Care provider;
2. A narrative describing how the Medical Home satisfies Basic Requirements criteria (a) through (h) specified in the contract;
3. A narrative that includes specific examples of processes and outcomes detailing how the Medical Home, in conjunction with the care coordinator, provides comprehensive and patient-centered care, and correctly identifies the needs of the member;
4. Quality data findings from quality findings listed under (f) in the contract;
5. Status report on patient access standards from (b);
6. The number of new members recruited to the Medical Home for that year as of the time of the report, and;
7. Any corrective action that is being taken to meet the requirements of the Medical Home pilot.

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#### Payment Structure

CCH is vested in recognizing and rewarding the added value provided to patients through the medical home. Our proposed reimbursement model provides enhanced reimbursement to our medical home providers beyond what is covered under regular Medicaid fee-for-service and compensates providers for the management of a patient's health care needs across the continuum of care.

The proposed payment model will consist of the existing fee for service reimbursement methodology which is in place with the contracted clinics.

As elaborated earlier, effective January 1, 2011, Medical Home providers that complete and submit the NOP by fax to CCH will be eligible for a financial incentive of \$25.

CCH will develop a wide-spread promotion of the Department's proposed additional payment of \$1,000 per good birth outcome to the OB-care provider, starting July 1, 2011 (in addition to the \$1,000 payment for births to members enrolled in the medical home).

In addition, CCH will employ a case coordinator to serve as a single point of contact for the pilot. CCH will also provide part time on-site outreach staff to pilot sites to reduce administrative burden

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and support medical homes sites in investing in the infrastructure and process changes necessary for the successful implementation of the pilot.

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**HMO Representative**

CCH is committed to working in partnership with the state and key providers in the community to design and implement a new medical home pilot for pregnant women who are at risk for having a poor birth outcome. We understand that this is an important public policy priority for the Department and we are committed to providing the necessary resources and staffing to ensure the successful design and implementation of the medical home model in accordance with the contract requirements.

Bruce Kruger, Director, Field Operations, based in Milwaukee, Wisconsin is the executive sponsor and accountable for the successful implementation and oversight of the medical home pilot. Subject matter expertise will be provided by Harvinder Sareen, PhD, MPH, Director of Clinical Programs, based in Camarillo, California.

Item/Details	HMO Plan – Children's Community Health Plan		
<b>Member Outreach</b> <ol style="list-style-type: none"> <li>1. Describe how the targeted population will be identified.</li> </ol>	<p><b>Children's Community Health Plan (CCHP):</b> The members will be identified in collaboration with our provider partners, utilizing the pregnancy referral form, member self identification, new member enrollee list, Healthy Birth Outcomes report from DHS, Emergency Department and any other sources utilizing the high risk criteria the state has set forward as the guideline. To simplify this process for the clinics, CCHP will continue to use the pregnancy referral form familiar to all providers as it was developed in cooperation by all of the HMOs and will work with the HMOs to enhance the tool to identify potential members for the pilot.</p> <p><b>Specific approaches used by our partner clinics follow:</b></p> <p><b>Sixteenth Street Community Health Center (SSCHC):</b> Pregnant patients are identified through diagnosis of pregnancy at a medical clinic visit, or through self referral from the community. Self-referral is done mostly through word of mouth and reputation. Identification of patients as qualified to be a part of the OB Medical Home pilot will happen through the initial OB visit, or through the initial OB case manager interview.</p> <p><b>MCW Family Medicine Clinics:</b> See No. 2 below</p> <p><b>St. Joseph's OB Residency Program:</b> There are several ways that women present for prenatal care. We currently are running a pilot program that coordinates care for women that presented to St. Joseph's Emergency Department without an established OB provider. Since the beginning of this pilot we have increased the number of women that initiate prenatal care before 15 weeks from 41% to 54%. We are in year two of the pilot and we are beginning to reach out to other Wheaton Emergency Departments that might see pregnant women. We also have a very close relationship with the labor and delivery triage area at St. Joseph. Some of these women will be eligible for the home model if the restrictions of enrollment are eased. Many of our women come to us from word of mouth or their own experiences. 45% of our pregnant women were seen in the clinic at some time before they began their pregnancies. All new OB patient charts are reviewed in a multidisciplinary case conference held weekly and every chart is reviewed by the CNM in the clinic after each visit. Identifying patients that can be included in the Medical Home Pilot will be fairly easy to accomplish within a few days of beginning care in the clinic.</p> <p><b>LifeTime OB/GYN:</b> As patients telephone in for an appointment a brief checklist will be completed to preliminarily identify those patients meeting the Pilot criteria. Patients who qualify with any 2 required criteria will be referred an OB team member for further review for eligibility.</p> <p><b>CCHP:</b> The program will be described as an enhancement to the usual prenatal care services now offered at CCHP, partnering with the members to help them meet their goals in achieving improved health status for themselves, fetus and family</p> <p><b>SSCHC:</b> Will distribute information to prospective patients about the pilot program.</p> <p><b>MCW -Family Medicine Clinic Sites</b> ( including Waukesha Family Medicine, Wheaton/Glendale</p>	<p>DHFS</p> <p>Page 1 12/27/2010</p>	

<p>Family Medicine and Columbia-St. Mary's Family Medicine residencies):</p> <ul style="list-style-type: none"> <li>• Posters in the lobby areas</li> <li>• Websites</li> <li>• Protocols for the intake process and the initial OB visit will incorporate providing information about the OB Medical Home and its benefits to the patient</li> <li>• Building in on-going discussion about the OB Medical Home into OB group visits as part of the Centering Pregnancy experience.</li> </ul>	<p>A family medicine faculty is a regular contributor (2 times/month) on TV Channel 6; she will incorporate references to the OB Medical home into her ongoing discussion.</p> <p><b>St. Joseph's OB Residency Program:</b> After appropriate scripting is developed either the social worker, registered nurses, PNCC or provider will describe the home and benefits to the patient. Once the patient has been identified it will become someone's responsibility to communicate with that patient concerning the medical home. The responsibility will fall on the NP/CNM to make sure that identified patients are informed of the model!</p> <p><b>LifeTime OB/GYN:</b> OB team member (MD, Nurse/MA, or PNCC) will provide patient with verbal and written information at time of first clinic visit.</p>
<p>3. Describe who will perform the outreach.</p> <p><b>CCHP:</b> outreach will be performed by Care Coordination Outreach Assistant, Social Workers and/or Nurses associated with the program.</p> <p><b>SSCHC:</b> Following HMO outreach, SSCHC is able to accept referrals of pregnant women.</p> <p><b>MCW- Family Medicine Clinic Sites:</b></p> <p>Integrating activities with the HMOs, the clinic's Prenatal Care Coordinator/or care coordinator depending on the site will either coordinate outreach by nursing staff or provide the outreach directly via phone, mail and email contact as well as home visits.</p> <p><b>St. Joseph's OB Residency Program:</b> We have several avenues of outreach in the city. As previously stated we have developed a close relationship with St. Joseph's Emergency Department and Labor and Delivery triage areas. We also have a strong word of mouth following. Many of our patients are friends and sisters of other patients. Our social workers and Prenatal Care Coordinators have many relationships in the community. We receive patients from other providers in the community that do not feel capable of handling many of our patients' high medical and psychosocial risks. We work with the Milwaukee Jail, the Black Health Coalition and the African American Breastfeeding Alliance and receive referrals from them. The clinic also does outreach at community events such as high school career fairs and other community events. We also have strong relationships with the public health department. The clinic CNM sits on the Fetal/Infant Mortality Board and works closely with many other community stake holders to decrease fetal/infant mortality.</p> <p><b>LifeTime OB/GYN:</b> At our offices, posters and general informational materials provided to us by the HMO will be made available to all patients. Patients who are identified as qualifying for the pilot program will be individually counseled by the OB team and encouraged to participate in the pilot.</p>	

<p>4. Describe how the HMO will collaborate with existing community groups and other stakeholders as part of their outreach strategy.</p>	<p><b>CCHP:</b> The HMO will continue to utilize the community for referral and resources as in the past with our Prenatal Care Coordination program. Outreach will continue to community groups, WIC, Black Health Coalition, Breastfeeding Coalition, Hospital Collaborative, FIMR group, MCH State Advisory group (as examples of a few) attending any meetings to network and collaborate to support the members</p> <p>5. Describe how the medical home will be explained to the member along with how she should use this medical home practice (e.g. hours, when and where to seek afterhours care, getting information by phone or email).</p>	<p><b>CCHP:</b> The member will be given information on the medical home site they will be obtaining services from (each medical home will have unique practices and contact information). The member will be connected with a Care Coordinator either based at CCHP or with a care coordinator based at the Medical Home site. All of our partner clinics have policies and procedures in place to ensure that members have phone access to someone on their care team after hours should the need arise. Each clinic will educate members about their particular policies regarding making appointments and after-hours contact.</p> <p><b>SSCHC:</b> Patients receive information about use of our clinic through written materials distributed to each patient. Pregnant patients also access services/information through the OB case managers.</p> <p><b>MCW- Family Medicine Clinic Sites:</b></p> <p>The Family Practice care coordinators will explain clinic access procedures to women enrolled in the Medical Home OB pilot.</p> <p><b>St. Joseph's OB Residency Program:</b> All patients receive information verbally several times during their pregnancy on clinic hours, when to call and how to get medical help after hours. They all receive a pre-printed appointment card with this information and danger signs. All disciplines in the clinic take responsibility to keep patients informed of this important information.</p> <p><b>LifeTime OB/GYN:</b> Patients will be presented with all needed information verbally and with written instructions during their first clinic visit. After-hours care and contact information is given verbally by the physician and reinforced by care team members. Reinforcement as needed during all subsequent visits and phone calls.</p>
	<p><b>Member Retention</b></p> <ol style="list-style-type: none"> <li>1. Describe how the HMO will retain members within the Medical Home.</li> <li>2. Describe how the HMO will ensure that members keep and attend appointments.</li> </ol>	<p><b>CCHP:</b> A Care Coordinator (nurse or social worker) will be assigned to each Medical Home Pilot site <b>and</b> the enrolled member if the member does not have a care coordinator based at the Medical Home Pilot site; incentives (for example – cell phone minutes, baby items, gift cards) will be used to keep the member engaged in the pilot; a consistent care coordinator will serve as a liaison between the medical home site and the client and CCHP. During off hours, evening and weekends CCHPs nurse triage line accepts calls with a nurse available on call as a backup mechanism if patient isn't able to reach her usual contact.</p> <p><b>CCHP:</b> A Care Coordinator will be assigned to each Medical Home Pilot site to enable collaboration with the healthcare provider, with availability by cell phone and computer for easy accessibility. Either CCHP or the clinical sites will assist Medical Home OB pilot program members with signing up for free cell phone through the Tracfone service, if the member wishes.</p> <p><b>SSCHC:</b> OB case manager available to make a reminder phone call to each patient prior to their appointment, and to follow up on any no-show appointments.</p> <p><b>MCW- Family Medicine Clinic Sites:</b></p> <p>Each clinic has policies that include the following components for key conditions including</p>
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pregnancy:

- Pre-visit planning that includes both patient and provider reminders
- No-show follow-up; patients who no-show are contacted and informed of the importance of keeping appointments as well as the consequences of not keeping appointments. OB no-show follow-up will be conducted by the OB Care Coordinator who will assist the patient in addressing barriers to keeping appointments or other elements of the care plan.

**St. Joseph's OB Residency Program:** The clinic already has several ways to ensure visits are kept. We do reminder calls for all patient appointments. Patients that 'no show' are called by an RN and reminded of how important appointments are and offered an appt within the next few days. We also have an incentive program collaborating with the March of Dimes and the Zeta Sorority that provides baby items in exchange for coming to visits and following through on care plans. Patients receive 'points' for coming to visits and participating in a variety of learning opportunities. In exchange for the points, they can go shopping in the Stork's Nest and 'buy' baby items. We also are completely flexible when it comes to meeting patient needs for appointments. We do not refuse to see patients that come late and we work very hard to keep patient wait times to a minimum to encourage compliance. We also run an evening clinic one night a week to help teens that are in school and working moms. We encourage women to come to their first visit by offering them a pack of diapers for their new baby.

**LifeTime OB/GYN:** See No. 3 below

**SSCHC:** The Centering Pregnancy program is an excellent vehicle to address patient education and follow through. In this program, patient education is self-led such that the patients themselves identify topics they'd like to learn more about, in addition to the curriculum content designed for each month of pregnancy. The group/dynamics encourage follow through. The OB Case manager will be available for education and support as well.

**MCW Family Medicine Clinic Sites:**

- A component of the initial OB visit will be to engage the patient in developing a plan of care.
- With the use of our electronic health record, we will track the patient's progress relative to the plan of care.
- In addition to providing the health check-ups, group visits, as part of the Centering Pregnancy provide ongoing opportunities for peer support. The importance of each patient's care plan will be emphasized.
- Wheaton/Glendale Family Practice site is a Stork's Nest Program site which awards points to patients for attending doctor visits, engaging in healthy behavior, i.e. quitting smoking, attending educational programs, etc.
- Waukesha Family Practice care coordinators will work in coordination with the PNCC nurses from Waukesha County Public Health to help patients understand and follow treatment plans throughout their pregnancy.

**St. Joseph's OB Residency Program:** Please see response to question #2 just above. The clinic also has created a very caring and accepting atmosphere. Patients know they will not be

3. Describe how the Medical Home will encourage members to follow a treatment plan throughout the pregnancy.

<p>judged for being late or for no showing and nothing but praise is offered when patients do come to their appointments and follow through on their care plans. RNs have created a comprehensive teaching care plan that follows the patients through their entire pregnancy (more opportunities for points). All patients have a social worker available to them at all visits to help them and all patients see the social worker at least twice in the pregnancy.</p> <p><b>LifeTime OB / GYN:</b> Will utilize incentives provided by the HMO as well as educating the member as to the importance of plan compliance.</p>	<p>4. Describe how the HMO will collaborate with existing community groups and other stakeholders as part of their member retention strategy.</p> <p>5. Describe how the care coordinator and medical home staff will establish a rapport with members.</p>	<p><b>CCHP:</b> The HMO will utilize and collaborate with any and all community groups that serve as resources and referrals to assure the member has met their needs (for example a referral incentive will be provided to any organization that provides referrals to the HMO of any identified pregnant members)</p> <p><b>CCHP:</b> The care coordinator and the Medical Home Pilot staff will have routine encounters as clients are seen at the Medical Home Pilot site. The Care coordinator will have a phone and a wireless computer to facilitate real time communication between all parties. There will be continued and as needed collaboration to meet the needs of the client.</p> <p><b>SSCHC:</b> OB Case Manager performs an initial intake visit either in person or over the phone. Based on the requirements of this pilot project, ongoing rapport will be maintained through monthly home visits. The Centering Pregnancy program would also work to build rapport and open communication with the patients</p> <p><b>MCW Family Practice Clinic Sites:</b> A Care Coordinator or Prenatal Care Coordinator meets with the pregnant woman when she first presents to the clinic. She conducts a prenatal assessment and establishes the level of support that she might need to promote a healthy pregnancy. She connects the patient with appropriate community resources. Throughout the pregnancy, she communicates with the patient regularly, by phone, at home and when the patient comes into the clinic.</p> <p><b>St. Joseph's OB Residency Program:</b> Rapport is established with the patients through continued client and provider engagement</p> <p><b>LifeTime OB / GYN:</b> Our one doctor/one nurse approach and our organizational workflow in general work to establish a close and trusting relationship with all of our patients.</p> <p>6. If a member misses an appointment, describe the follow-up procedures that the medical home and/or the HMO will engage in step-by-step.</p>
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	<p>the patient receives care.</p> <p><b>SSCHC:</b> OB Case manager will contact the patient to identify any barriers to keeping appointments and will reschedule the appointment. Referrals will be made to other services, as needed to address the barriers identified to keeping appointments.</p> <p><b>St. Joseph's OB Residency Program:</b> When a patient no shows we will try to call her that day and encourage her to come. If we cannot reach her, the triage RN takes responsibility for following up by phone and if we can not reach her by phone we will send certified mail.</p> <p><b>LifeTime OB/GYN:</b> has in place policies and procedures regarding missed OB appointments that require at least two attempts to contact patients to reschedule the appointment and stress the need for consistent and regular prenatal care. If the member misses two consecutive appointments the HMO PNCC will be notified for additional follow-up. Additionally, written communication takes place as needed.</p>
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#### OB First Contact of Care

1. Describe in detail how the OB-Care provider will function as the first contact of care or point of entry for the member.

	<p><b>SSCHC:</b> Upon diagnosis of pregnancy, or patient call an appointment is made with the OB provider. At that initial appointment, a "new OB" history and physical exam is obtained, and prenatal care is initiated. SSCHC functions as a medical home already; some prenatal patients are cared for by family physicians that also function as their PCP for regular medical issues; others see Certified Nurse Midwives (CNM) who work cooperatively with family physicians and internists who will fill the role of PCP for all patients cared for by CNMs during pregnancy.</p> <p><b>MCW Family Medicine Clinic Sites:</b> Within each practice each member will be assigned a primary care provider (PCP) at their first appointment. That PCP will function as the leader of a team which is responsible for coordinating all aspects of each member's care, both obstetrics and primary care. All regular appointments will be scheduled with the PCP. Urgent or same day appointments will be scheduled with the PCP if possible. If the PCP is not in clinic on a particular day appointments will be scheduled with another member of the same team.</p> <p><b>St. Joseph's OB Residency Program:</b> The OB provider may not be the first person a patient sees in the clinic. Since we require no proof of insurance, we often times have women come in to see the financial counselor or social worker to help begin the insurance process. Patients that request care in the clinic will have an appt with the RN and MD within 7-10 days of initial contact. There is always a provider or RN available to provide a referral to the social workers and Prenatal Care Coordinators (PNCC) if the patient requires any assistance with obtaining insurance when meeting with a patient.</p> <p><b>LifeTime OB/GYN:</b> MD and Nurse will identify patients who meet criteria for the pilot on the first visit. Patient will be counseled about the pilot program and asked to enter. Specific needs will be assessed by care team and recommendations and/or referrals made as appropriate. Each patient entered into the pilot study will be clearly identified within the practice for all care providers. The "Risk Factors Identified" section of the prenatal record will be marked to indicate enrollment in the pilot study.</p>
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2. Describe how the medical home team (clinical staff, nurses, lead OB-care provider, and other providers) will function.

**SSCHC:** One medical provider (CNM or FP Physician) assumes primary responsibility for the pregnancy. Every attempt is made to make appointments with this primary provider throughout the duration of the pregnancy and the postpartum period. OB Case Managers interact with all of our OB care providers. Lactation consultation is also available.

**MCW Family Medicine Clinic Sites:**

Each practice is divided into patient-care teams, consisting of physicians, midlevel providers, nursing personnel (RNs, LPNs and/or medical assistants) and front-office staff. At two sites pregnant patients also receive the services of a prenatal care coordinator. The care team is further aided a comprehensive electronic medical record that includes prenatal templates to guide care and registry capacities enabling the teams to track their prenatal population. Team members provide outreach and education and, in conjunction with the PCP, provide referrals to relevant community resources. The team also coordinates with its practice's community hospital OB unit.

**St. Joseph's OB Residency Program:** The Certified Nurse Midwife (CNM) or Nurse Practitioner (NP) in the clinic will take responsibility for making sure that all care plans are

established and followed through. Most high risk women see a resident physician in conjunction with the CNM or NP and consultation with a maternal fetal medicine MD. While resident physicians may rotate through the clinic, the CNMs and NPs are stable and provide continuity of care. Again, through a very comprehensive program OB case managers, social workers, RNs and all providers work together and communicate through both verbal and written means to provide care to our very complex patients.

**LifeTime OB/GYN:** One obstetrician is responsible for the care of the pregnant and post-partum patient. Each physician has a dedicated nurse who interacts with both patient and physician to coordinate care. Additional clinical staff including PNCC and resources will be involved as needed. The prenatal flow sheet will be used to document encounters/referrals and for reference by all clinical team members to ensure good flow of information to all team members.

**Written Standards for Access and Communication**

1. Describe the written access standards that the Medical Home will adopt. Include appointment wait time standards.

**SSCHC:** written access and wait time standards that are consistent with NCQA standards

**MCW Family Medicine Clinic Sites: access standards are consistent with NCQA**

**St. Josephs' Obstetrics Residency Program:** as noted elsewhere above, will see new pregnant patients within 7-10 days of initial contact. The clinic also has a generous no-show policy, often seeing women the same day of a no-show or within a few days at most.

**LifeTime OB/GYN:** has adopted acceptable guidelines for waiting times for office visits and telephone call responses consistent with those set forth by NCQA standards. LifeTime's goal is to offer an appointment within two weeks of the date of the initial phone contact to establish prenatal care.

2. Describe how these standards will meet the requirements that treatment and/or medical advice will be available 24/7.

Like the vast majority of medical clinics anywhere, all of our clinical partners provide 24/7 access to medical advice to appropriately triage problems to the right level of care. When clinics are not open, some form of after-hours coverage is available. Specifically:

**SSCHC:** Clinicians are available 24/7. When clinic is open, patients are able to talk with an OB Case Manager, or with the medical team of the OB care clinician. After the clinic is closed,

providers take call for all of the patients. Through the central phone number, patients are able to talk with the on-call provider. These instructions are provided to the patient in the written materials that all pregnant women receive.

#### **MCW Family Medicine Clinic Sites:**

Summary of relevant standards include the following:

- A. Phone Calls:
  - Emergency Calls
    - -Immediate life threatening– 911 will be contacted by nurse if caller is not able
    - Time critical situations
      - Calls will be transferred to a triage nurse. If this isn't possible call will be returned within 30 minutes.
  - Office-hours Call Management
    - Triage desktop will be assessed every 15 minutes. The order for returning calls will be based on the following guidelines:
      - Potentially serious situations – call returned within two hours
        - Problems that will need to be seen today
        - General medical/illness type problems
        - Non Urgent, test results and/or follow up problems
        - Calls about potentially serious situations & problems needing to seen today
      - All other calls will be returned by the end of the day
    - After-hours calls
      - A triage service is employed for after-hours phone calls. When needed, the doctor-on-call is paged for situations beyond the written scope of the triage service. Faculty physicians are on-call at all times.

**St. Joseph's OB Residency Program:** Physicians are available 24/7. Patients receive information on how to access an MD anytime the clinic is not open. There are always physicians in the hospital from the clinic and we have a system of documenting all patient phone calls during off hours and making sure they get to the patient chart.

Patients have access to a Registered Nurse during clinic hours. Calls are triaged and those that are emergent are handled accordingly. The RN always has access to CNM, NP or MDs if needed. Patients receive a pre printed app card that has information on how to get a hold of a health care provider at any time. Cards are in English and Spanish. Women who speak other languages have an interpreter at their appointments that can write the information in their language. Our phone system is set up to allow women to get the hospital operator by pushing 0. Even women that don't speak English can easily access the operator. Women are instructed how to share their language needs with whomever answers the phone and that person knows how to get the appropriate interpreter on the line. All of our secretarial staff speaks English and Spanish.

**LifeTime OB / GYN:** 24/7 access to treatment and/or medical advice is achieved by the use of an answering service and physician on call during hours clinic is closed. During clinic hours patients may speak with their nurse/physician/care coordinator.

3. Describe how ED use by the member will be addressed, including procedures that the medical home will engage in when an ED visit by the member occurs.

**CCHP:** Tracks and will inform the Medical Home Sites of any Emergency Department visits by the members enrolled in the pilot within 24 hours, or 72 hours on weekends.  
**SSCHC:** Urgent Care Clinic is available to patients from 0830 to 2030, Monday through Friday. Patients with urgent needs are able to be seen through this clinic or through walk in appointments as needed. Once SSCHC is aware of an Emergency room (ER) visit, an OB Case Manager will call the patient to give the patient education on appropriate use of the ER, clinic access policies, and other education as needed.

**MCW Family Medicine Clinic Sites:**

Use a combination of open-access scheduling procedures and same-day appointments for urgent needs that can appropriately be managed in the outpatient setting. Family Medicine clinics will be notified promptly of all ED visits by women in the pilot program, and will outreach to those patients to ensure timely follow up.

**St. Joseph's OB Residency Program:** We encourage patients to come to the clinic during normal clinic hours unless we deem the problem to be something that cannot be dealt with safely in an outpatient setting. We have same day and next day appointments and have created a system that allows us flexibility in the clinic for walk-ins and triage calls. Having an RN to educate and help women care for them has been instrumental in decreasing ED use. Women are also encouraged to call at night. Our MDs in the hospital have access to patient information and can help the patient make safe choices for staying home and coming in the next day. MDs merely leave a voice mail on a specially designated line with patient name and identifying info, phone number to reach pt at, problem and recommended visit time. The triage nurse listens to all messages at 8:00 and calls patients to help them come into the clinic ASAP. **LifeTime OB/GYN:** Patient with urgent needs are seen in the office or directed to the Labor and Delivery triage area of the hospital where patient plans to deliver. Patients are given instructions for emergency access to care as part of their prenatal care and counseling. When Emergency visit by a patient occurs, reinforcement of preferred procedures will be undertaken during subsequent patient encounters with their care team.

4. Describe how the HMO and clinic will meet the NCQA standard of providing same day appointments for routine and urgent care based on the practice's triage of patients.

**SSCHC:** Meets NCQA standards  
**MCW Family Medicine Clinic Sites:**  
A patient who requests a same day appointment will be offered an appointment with their assigned PCP, if available. If assigned PCP is not available, an appointment is offered with another team provider. In some cases patients may be offered an Urgent Care appointment. Management of same-day capacity:  
a. Same Day / Urgent Care appointments are identified for each provider when schedule is created.  
b. Adjustments are made after the schedule is reviewed one week prior  
c. Open slots are increased based number of providers in the clinic, time of year day of the week and the trends for volume of calls on those days.  
**St. Joseph's OB Residency Program:** Again, the clinic is set up to allow for same day visits. Either the RN or OB provider will establish when a patient should be seen and appointments will be made accordingly

**LifeTime OB/GYN:** has adopted acceptable guidelines for office visits and telephone call responses consistent with those set forth in the NCQA standards

5. How will you address and evaluate the relationship between providers and HMOs?

1. Describe the type of electronic health records that will be used.

#### Electronic Health Records

1. Describe the type of electronic health records that will be used.

**CCHP:** The HMO will have a liaison between each partner Medical Home; this role will be the function of the Manager of the Prenatal Care Coordination program. The manager will be easily available for regular communication via phone, email or in person as needed by the Medical Home Pilot site. The manager will conduct monthly visits (and as needed visits) with each site, review processes and any need for program improvement or programmatic change to facilitate success. In addition, the Medical Director will be available as needed to discuss clinic concerns that have not been resolved by other means.

#### Electronic Health Records

1. Describe the type of electronic health records that will be used.

**SSCHC:** uses an Electronic Medical Record system by Sage, called Intergy. It contains a module specific to OB care, called OB chart. The charting within the module is designed for monthly OB visits, tracking of labs, physical exam data etc. (St Mary's hospital, where our members deliver, has access to this system)

#### MCW Family Medicine Clinic Sites:

Each practice utilizes an office based electronic health record which documents each office visit, vital signs, medications, problem lists, care plans, etc, etc. Each record has an interface to the hospital lab system and receives lab results electronically.

**St. Joseph's OB Residency Program:** Wheaton Franciscan Healthcare St. Joseph uses an electronic system for storing patient information. All labs, ultrasounds, consult and ED visits done within the system can be accessed 24/7. All written materials are scanned into the digital record and are also available electronically.

**LifeTime OB/GYN,** Ltd. uses a paper medical record but has access to the Intelligent Healthcare Registry from which data can be inputted and extracted including billing and lab data. Additionally, Excel Spreadsheets can be utilized as appropriate and required.

2. List the information that will be available to the clinic through this system.

#### SSCHC:

Complete copy of the patient's OB chart

#### MCW Family Medicine Clinic Sites:

All the data tools required by the Level 3 recognition standards for the NCQA Patient-Centered Medical Home are available and searchable within the practices' electronic health record. They include the following:

- Patient information such as demographic, language preference, contact information, current and past diagnoses, dates of previous visits, health insurance coverage, and so forth.
  - Clinical patient information such as status of preventive services, allergies/adverse reactions, vital signs, and imaging, pathology and laboratory results.
  - Charting tools such as problem lists, over the counter and prescription medications, structured templates for risk factors assessment and counseling and narrative progress notes, and structured templates for specific conditions such as chronic disease (diabetes and hypertension), well-child checks and prenatal visits.

	<ul style="list-style-type: none"> <li>▪ Registry functions to produce lists of patients for monitoring or contact for activity such as pre-visit planning, reminders for preventive care, follow-up care or specific tests, and those on a particular medication</li> <li>▪ Test, imaging and referral tracking</li> </ul> <p>Prescription writer that includes features such as automatic alerts, generic identifier, and capacity for e-prescribing (electronic submission to pharmacy)</p> <p><b>St. Joseph's OB Residency Program:</b> The patient's entire chart is available through the system.</p>
3. Include the product name of the electronic health record system that will be used.	<p><b>SSCHC:</b> Interge by Sage</p> <p><b>MCW Family Practice Sites:</b></p> <p>Two of the three practices utilize the NextGen electronic medical record product; the third practice currently utilizes the GE Centricity product, but will be transitioning to the EPIC medical record product over the next two years.</p> <p><b>LifeTime OB/GYN:</b> Intelligent Healthcare registry</p> <p><b>St. Joseph's OB residency:</b> Horizon Physician Portal</p>
	<p><b>Implement Evidence-Based Practices</b></p> <ol style="list-style-type: none"> <li>1. List all nationally recognized evidence based guidelines (e.g. ACOG, CDC) for chronic disease and pregnancy that will be adopted by the Medical Home for the conditions listed under R2d.</li> </ol>
	<p><b>CCHP:</b> ACOG: Prenatal Care Guidelines, referral guidelines NHLBI: Asthma in Pregnancy; JNC7 for Hypertension; WI DM Collaborative; ADA: Diabetes</p> <p><b>MCW Family Medicine Sites:</b></p> <p>Some of the clinics' guideline topics and their sources include the following</p> <ul style="list-style-type: none"> <li>• Diabetes: American Diabetes Association (2010 Standards for Medical Care in Diabetes)</li> <li>• Hypertension: 7<sup>th</sup> Report of the Joint Committee (JNC 7) on Prevention, Detection and Treatment of High Blood Pressure</li> <li>• Hyperlipidemia: 3<sup>rd</sup> Report of the NCEP - Detection, Evaluation and Treatment of High Blood Cholesterol in Adults</li> <li>• Childhood Immunizations: ACIP, latest report</li> <li>• Adult immunizations: ACIP, latest report</li> <li>• Adult preventive services: United States Preventive Services Task Force</li> </ul> <p><b>St. Joseph's OB Residency Program:</b> ACOG guidelines; ACIP latest updates; 2010 ADA Standards for Medical Care; JNC 7; USPSTF</p> <p><b>LifeTime OB/GYN:</b> will adopt all of ACOG's practice guidelines for the management of chronic disease in pregnancy. The ACOG guidelines combine most nationally recognized and published guidelines. Will also use ACIP, JNC 7, USPSTF, ADA.</p>
2. Describe how the HMO will evaluate and ensure that these guidelines are followed.	<p><b>CCHP:</b> CCHP will receive, at a minimum, monthly dataset updates on the patients in the pilot Program. This will allow us to measure HEDIS prenatal and postpartum measures, birth weight, gestational age at birth, maternal conditions, breastfeeding rates, smoking rates, substance abuse. To verify these data, CCHP will periodically conduct chart audits and review claims (lab data – e.g., glucose challenge, ultrasound if indicated), and pharmacy data (prenatal vitamins, smoking products, antibiotics for STI tx).</p>

3. List all procedures for addressing the complex needs of women with these chronic conditions.

**CCHP:** Care coordination will be critical for all patients in the Pilot Program. Aggressive care coordination, whether provided by in-house resources in the clinic or by CCHP, will ensure that appropriate resources are marshaled to address medical, psychological, and social needs of high risk pregnant women.

**SSCHC:** Has well-established procedures and partnerships with specialists to take care of the full spectrum of patients' comprehensive health care needs. ACOG guidelines are used to determine when specialist referral is indicated in pregnancy.

**MCW Family Practice Clinic Sites:**

We will utilize our well-established referral network to address the more complex needs of our patients. Our referring physicians report to the Primary Care Provider (PCP). Our Prenatal Care Coordinators maintain contact with the patient, even after the patient has been referred out for ongoing care.

**St. Joseph's OB Residency Program:** A comprehensive care plan is established when patients enter into care. This care plan is created with the input of maternal fetal medicine, OB attendings, CNM/NP, PNCCs and Social Workers. Care plans are clearly documented on the 'problem list'.

The CNM/NP reviews all charts at every visit to ensure that care plans are being followed through. All consultations are documented and the chart is updated. The CNM/NP review all patient lab results, consultations, etc and follow through accordingly. We have both a verbal and written means of communicating with each other and other providers involved in the care of our patients. Weekly case conference is attended by the Clinical Nurse Specialist (CNS) of perinatal services at St. Joseph Hospital to ensure that care plans are carried out in the hospital as well as the clinic.

**LifeTime OB/GYN:** The above noted ACOG guidelines will be followed with appropriate referral to maternal fetal medicine specialists for co-management. These patients will be followed more frequently than routine prenatal visits.

4. Include procedures for appropriate referrals and how those procedures meet ACOG guidelines or other national standards.

**Patient Self-Management**

1. Describe how the Medical Home will engage and educate the member in patient self-management.

**SSCHC:** Preferred method of engagement is the Centering Pregnancy program, this program emphasizes self management. It is group directed, with an emphasis on education. Patients are taught self management techniques and strategies.

**MCW Family Practice Clinic Sites:**

The following strategies are employed at our practices:

- OB visits incorporate brief meeting with team nurse to assess self-management status
- Group visits/support
- Continue to provide child birth and parenting classes on site
- Encourage healthy behavior by awarding Stork's Nest points (see below)

To encourage patient involvement in self-management we invite the significant other to be a part

of the centering pregnancy classes and the parenting support group, which is lead by one of our social workers. The parenting class helps expecting mother preparing for child-rearing and to help siblings prepare for the arrival of the new infant to the family.

**St. Joseph's OB Residency Program:** The RNs, PNCCs and Social Workers have created specific teaching plans that address specific barriers and problems in our community. Smoking cessation, breastfeeding initiation, marijuana reduction, diabetes management are all examples of the types of education that our RN, PNCCs and Social Workers (SW) engage in. We have several ways to encourage self management including pt driven education. We have surveyed our entire population of obstetric patients several times in the last few years to allow them to tell us what they need to learn and how they would like to learn. They also have an option of self educating with several culturally competent and health literate DVDs and classes that they decide to participate in and receive storks nest points for accomplishing. We track outcomes consistently and participate in program evaluation. Specific examples of what is tracked and how are available to the HMO if they would like to see the information.

**LifeTime OB/GYN:** Emphasize education and use of all pertinent materials available. Additional referrals to community organizations as appropriate (for example: Rosalie Manor for teen parents support) Each OB patient is presented with a wide variety of written materials upon first visit

**CCHP:** Gift cards and/or cell minutes will be provided to the member for keeping appointments We will also offer a cell phone and minutes through a national vendor (TracFone). These items could change at any time during the program--if they are not effective in keeping members engaged, we will explore other options.

**SSCHC:** will utilize incentives provided by the HMO

**MCW Family Medicine Clinic Sites:**

Our sites are current Stork's Nest Program sites which awards points to patients for attending doctor visits, engaging in healthy behavior, i.e. quitting smoking, attending educational programs, etc. The points are used at the postpartum visit to purchase new baby items such as diapers, clothes, toys, car seat, and small furniture. Evaluation of the Stork's Nest program indicates it positively influences compliance with good OB care. Additionally, our sites provide on-site child care during parenting classes and offer a light meal at both the pregnancy and parenting support group sessions.

**St. Joseph's OB Residency Program:** Storks Nest, car seat class (women that take a class with our certified car seat technician receive a free car seat for their new baby. Women are eligible for the class after 35 weeks. Women that deliver prematurely can take the class before they take their baby home) St. Joseph's also has a safe sleep program wherein women receive a free halo sleeper and pack n play for engaging in safe sleep education. We also have a smoking cessation program that provides gifts as incentives for women that participate and we have incentives for women that initiate breastfeeding in the hospital. Women receive extra storks nest points for all of these activities as well.

**LifeTime OB/GYN:** will utilize incentives provided by the HMO

2. Describe any member incentives that will be used for the member to engage in patient self-management, if any.

3. Provide or describe any tools or educational materials that will be used in the patient self-management strategy.

**CCHP:** The member will be given materials during the pregnancy and postpartum period if needed to supplement materials the Medical Home Pilot sites are using which may include: the book "Baby Basics, Wisconsin Women's Health Guide, "When Your Child Gets Sick", and other literature as appropriate

**SSCHC:** OB education booklet distributed by CSM and Centering Pregnancy materials, birth control, information and education.

**MCW- Family Practice Clinic Sites:** A resource book outlining the OB process is provided and reviewed by the care coordinator nurse at the time of the initial OB visit. This book is provided in both English & Spanish. Other materials are provided based on the needs of the patient.

**St. Joseph's OB Residency Program:** We have a plethora of culturally competent and health literate written materials, videos, group classes for breastfeeding and one on one sessions with an RN. These materials are in English and Spanish and we use interpreters for other languages. We have created our own resource guide for MDs and patients in a very health literate manner in English. We are trying to get translated into Spanish. We only utilize material that our own committee as reviewed to ensure it is culturally competent, accurate and health literate before giving it to our patients. We are creating a process now that would allow our patients to also contribute their thoughts to the materials we use and we do surveys as well.

**LifeTime OB/GYN:** OB education booklets distributed by WFHC and WAMH as well as various brochures and pamphlets that discuss a broad range of obstetric topics. All materials developed by the HMO for use with the pilot program will be distributed at our site to our patients.

#### Measuring Practice, Physicians and Reporting

1. List and describe all measures that the HMO will measure the Medical Home and individual physicians on.

**CCHP:** HEDIS pregnancy measures, Lab results – OB panel, Quad Screen if done, GBS, O'Sullivan; Alcohol use, Substance/Tobacco use; vital signs at each visit including weight, blood pressure, urinalysis if done, Breastfeeding , Ultrasounds if done; ED visits for non-emergent issues; receipt of Rhogam if indicated; referrals where indicated

2. Explain why these set of measures are the most appropriate to measure the effectiveness of the Medical Home and the individual physicians.

These measures represent best practices in the monitoring and management of high risk pregnancies at this time.

We will share data monthly at a minimum. Data transfer will be 2 ways—from clinic to HMO, and HMO to clinic. We will use a uniform data tool that has been developed cooperatively by the 4 health plans, with input from the clinics, in order to make data gathering simpler. We have developed a data format in Excel, common software that is familiar to all our partners.

3. Describe how often the HMO will report on these measures to the Medical Home, physicians, and members, and in what format.

4. Describe the experience and capacity that the HMO has to run these quality measures.

Our experience with this is informed by the frequent and recurring need to examine outcomes for a variety of conditions as required the state of Wisconsin. In addition, our Medical Director has experience with developing new datasets for the assessment of quality of care as a fellowship-trained and grant-funded researcher.

#### Cultural Competency

1. Describe how the HMO will ensure that cultural competency will be incorporated within the Medical Home and in the delivery of care to members.

**CCHP:** Each employee of CCHP must complete cultural competency education, learning seminars will be conducted during the year to cover cultural and ethnic practices Children's Hospital and Health System (CHHS) strives to embrace diversity and support cultural competence in numerous ways. CHHS is committed to creating and sustaining an environment that utilizes each individual's talents, maximizes their potential and welcomes their contributions. CHHS has an active Diversity Committee that provides ongoing opportunities for education and awareness of issues. Each and every CHHS employee completes full-day training within the first 90 days of their hire date. This class actively reinforces how every employee supports a work environment that respects **and values everyone (R.A.V.E.).** The CHHS intranet, available to all employees, contains additional resources available to ensure the cultural competence of all staff. Grand Rounds are held weekly at Children's Hospital and often focus on issues related to cultural competency.

2. Describe how members will have appropriate access to interpreter services.

**CCHP:** has a contract with Pacific Interpreters as a resource for members to fulfill any need for translation. In addition, the system employs interpreters which can be enlisted to assist in a face to face interaction

**SSCHC:** has bilingual (Spanish) abilities in all areas of patient flow and care

**MCW Family Medicine Clinic Sites:** Interpreter Services are available at all the sites Waukesha Family Practice Clinic (WFPC) serves a large Hispanic population. Our interpretation needs are met by:

- A full-time Spanish interpreter, she is also able to translate any written documents into Spanish when needed
- 2 of our care coordinators speak Spanish
- 3 of our physicians speak Spanish
- 7 of our front office staff also speak Spanish
- We use an outside service for several of our patients who need to use sign language

When other languages are needed we utilize a language line. We have speaker phones in 4 of our exam rooms to assist the providers when other languages are spoken.

**St. Joseph's OB Residency Program:** The clinic has access to a Spanish speaking interpreter all day long during clinic hours and many of our OB providers, nurses, social workers and secretaries speak Spanish. All phones in the clinic are hands free and interpreter ready. We have access to any language through the language line. Women coming in for longer visits such as their first visit or postpartum have an interpreter ordered for them from our language resource center. Approximately, 60% of our patients speak English, 30% speak Spanish and other languages are Urdu, Arabic, Chinese, Russian, French and several African languages.

**LifeTime OB/GYN:** The clinic has a contract with Language Source to provide interpreter service as needed. Members with LEP are identified when first appointment is scheduled and interpreter needs are recorded in patient records.

3. Describe the training, policies and procedures that the Medical Home clinic has in place around cultural competency.

**SSCHC:** lives and breathes cultural competency. The majority of employees live in the community that is served. Cultural competency is required of all clinicians at recruitment, and periodic CME trainings are provided for clinicians and the staff receives diversity training on an annual basis.

**MCW Family Medicine Clinic Sites:**

All physicians and employees are required to attend yearly cultural competency education.

**St. Joseph's OB Residency Program:** Wheaton Franciscan Healthcare has an entire cultural competency program that every associate must go through before working in the system. The clinic has created our own system of learning from our patients and working with each other to provide culturally competent care. It would be virtually impossible for the clinic to be experts in every culture we serve; therefore, we have created an atmosphere where we continually learn about the women and families we serve. We also educate ourselves and each other when we encounter new cultures through journal articles, personal experiences and inviting experts from the community to come in and speak to us. We hold ourselves to a very high standard in the clinic to meet our patients' needs. We have a diverse population of staff members and we continually try to reflect our patient population. Our philosophy is that our patients are the best teachers of cultural competence and we rely in their needs and expectations to create our processes.

**LifeTime OB/GYN:** Our practice has a diverse patient base built upon 25+ years of serving our community. We have ongoing referral relationships with a culturally diverse population. We believe this serves as testament to our sensitivity to the needs of many different peoples and cultures. Our broad experiences are shared within the clinic by physicians and staff members alike to address specific needs of differing cultures. Cultural Competency is regularly addressed with all clinic staff during staff meetings. Additional handouts will be offered for self-study. Outside CME will be utilized as appropriate

**SSCHC:** not applicable to SSCHC

**MCW Family Practice Clinic Sites:**

We have a Patient Advisory Council made up of a cross-section of patients who represent our practice. The group advises our practice on issues that relate to the care that we provide, including cultural competency and the impact that our practice has on the broader community. The Waukesha Family Practice Site also works with the Hispanic Resource Center, located in the same building, to assist with meeting the cultural needs of our patient population.

**St. Joseph's OB Residency Program:** See above comments.

**LifeTime OB/GYN:** As above. We are always open to meet or speak with representatives of existing groups to refine our understanding of the community's needs.

**Care Coordinator**

1. List all activities and expectations of the Care Coordinator. Please describe the activities by week of pregnancy and post-partum.

Care coordinator activities and expectations will be similar across all sites. These include: Risk Assessment, referral to appropriate social service agencies/specialists as needed, health education, home visits if granted consent, breastfeeding education and support, sleep safety education and support; data gathering and input for data collection tool to be shared with HMO; being present at prenatal visits as frequently as possible.

<p>2. Describe what qualifications the Care Coordinator must have.</p>	<p><b>CCHP:</b> The Care Coordinators are nurses and social workers who have experience in the Prenatal Care Coordination program and knowledge of the Medicaid population, high risk pregnancy, and the social issues that are encountered by this population. In addition, the staff is very familiar and understand the Life Course Theory promoted by Dr Lu which is beginning to be adopted as best practice in the community</p> <p><b>SSCHC:</b> State requirements – care coordinator must be an RN or Social worker- SSCHC would like to investigate use of other staff. Our Coordinators are either an MSW or an RN. She is assisted by a prenatal care coordination paraprofessional, who has an associate's degree. The paraprofessional's cultural background is consistent with that of the majority of our patients.</p> <p><b>MCW – Family Practice Clinic Sites:</b> employ RNs and/or Social Workers to assist with care coordination</p> <p><b>St. Joseph's OB Residency Program:</b> MSW or BSN with a minimum of two years experience. We already have four MSWs and one BSN who has PNCC and Social Work experience</p>
<p>3. Describe any patient advocacy activities that the Care Coordinator will engage in.</p>	

#### Discharge Plan

1. List all activities to take place for the member and child for the first 60 days post-partum, beginning with the discharge from the hospital following birth.

**CCHP:** The care coordinator will visit the client in the hospital setting after the birth of the baby to determine any needs the client might have, discuss benefits, and education as needed. At the time of the hospital visit the care coordinator will set up an agreed upon time to visit the member within the first week to assess any needs for education or advocacy.

**SSCHC:** Each postpartum mother and baby receives a home visit by one of the RN Case Managers or one of our OB outreach workers. These staff members assist the other in the first few days of the postpartum period with education, concerns and with breastfeeding. These staff members serve as a liaison with the pediatrician and/or the OB provider.

**MCW Family Practice Clinic Sites:**

- The child is seen each day in the hospital
- Home visits are conducted as needed
- The child is seen for a 2-week visit
- The mother is seen for her postpartum exam at which time she is able to use her Stork's Nest points to "purchase" new baby items
- The child is seen for a 4-week visit
- Telephone contact is maintained with the mother throughout

**St. Joseph's OB Residency Program:** See No. 3 below

**LifeTime OB/GYN:** Patients are sent home with appropriate community and medical referrals and instructed to return for their post-partum visit with their obstetrician.

Pap, Birth Control Education, Intrapartum Education (related to birth spacing, self care); See Above comments in Section – Evidence Based Practice No. 2

**LifeTime OB / GYN:** ACOG post-partum guidelines and a plan for care are incorporated into our office exam records completed during the post-partum visit. At the post-partum visit the patient will be reminded to continue to see their provider for routine OB/GYN screening and are referred back to their PCP for any other medical needs.

3. Describe how the HMO will transition the member's care to their PCP.

**CCHP:** The care coordinator will, during the pregnancy have worked with the client to assure that the client has selected and feels comfortable with the PCP. The Care coordinator can during the pregnancy if needed set up and attend an appointment with the PCP. During the pregnancy the care coordinator will be working with the client toward self management.

**SSCHC and MCW Family Medicine Residencies:** these clinics use either a family medicine model for obstetrical care or have multispecialty primary care services under the same roof—either way there is a seamless transition from obstetrical care to primary care for mother and baby.

**St. Joseph's OB Residency Program:** The clinic works with many different PCPs and pediatricians in the community. If the patient has an assigned PCP, we will notify them that the patient has delivered. We still provide some primary care and interconceptional care for our patients and have established a close relationship with the MCW Family Medicine Clinics to help women transition to a PCP.

**LifeTime OB / GYN:** Has established connections with the MCW Family Medicine Clinics which works in the same hospital and cares for many of the patients delivered by LifeTime.

**Reporting to DHS**

The HMO will report to DHS as specified in the contract

DHFS

12/27/2010

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<b>Payment Structure</b>	The HMO will pass the money to the Medical Home Pilot site that has reported the birth and maintained compliance with the guidelines of the program
<b>HMO Representative</b>	<p>1. Identify the HMO staff person in charge of overseeing the implementation of the Medical Home Pilot.</p> <p>Lynn M. Kryfke, RN, MSN Phone – 414-266-7951 lkryfke@chhw.org</p>

Abri  
Health Plan



# Medical Home Pilot Plan

Submitted to the Department of Health Services  
by Abri Health Plan, Inc

September 30, 2010

The Medical Home pilot program being submitted will continue to be refined through regular meetings with Abri's Medical Home pilot sites and the other three RFP HMIs over the next three months in preparation for a "go live" date of January 1, 2011.

The following changes were made to the Medical Home pilot program that was submitted with the RFP:

1. Two of the Medical Home sites, Dr. Arena and Dr. Melenchenco, were replaced because the size of the medical practice proved to be too small to support everything required in the pilot. One new site was added- Sixteenth Street Community Health Center. Abri's final sites are:

(1) Columbia St Mary's OB/GYN Residency Clinic

2320 N Lake Dr, Milwaukee

DHS contact: Clarissa Azcueta Cox RN, 414.961.3384, ccox1@columbia-stmarys.org

Clinical contact: TBD

(2) Wheaton Franciscan Health St. Joseph Hospital Women's Center

5000 W Chambers, Milwaukee

DHS contact: Kris Krueger, 414.465.3106, Kris.Krueger@wfhhc.org

Clinical contact: Mary Mazul RN, Mary.Mazul@wfhhc.org

(3) Sixteenth Street Community Health Center

1032 S Cesar E Chavez Dr, Milwaukee

DHS contact: Julie Schuller, M.D., 414.385.3366, Julie.schuller@ssschc.org

Clinical contact: Karen Lupa APNP, Karen.lupa@ssschc.org

(4) LifeTime OB/GYN

17280 W North Ave, Suite 200, Brookfield

DHS contact: Sue Hill, 262.754.8000, suehill@lifetimeobgyn.com

Clinical contact: same

2. Abri is in the process of employing a new Medical Director who will assume responsibility for the Medical Home pilot. In the meantime, the Abri staff member identified in the RFP who was to be in charge of the pilot has changed. The previous staff member, Suzanne Cook, is on medical leave and is unable to assume the responsibility. The new staff head is Patricia Delaney. Her resume is being submitted at this time.

Abri is submitting the program response reflective of the collaborative nature of this pilot. Each area response shows the responses of the Medical Home sites based on their own specific programs and where appropriate, indicates Abri as the Health Plan's role(s). Three of the Medical Home sites selected by Abri are fully functional as prenatal Medical homes. The fourth site is a smaller provider practice and requires more assistance from the Health Plan. Abri's role is to work with the sites to support their programs, provide assistance and additional services to the women in the pilot program that the sites cannot provide as well as one of oversight and evaluation.

Activities	HMO Plan
Member Outreach	
1. Describe how the targeted population will be identified.	<p><b>Abri</b></p> <p>Internal Referrals—Abri employees with customer contact will immediately notify a prenatal Nurse Case Manager, via email, of Abri members who may be pregnant. Within 72 hours of an internal referral, the Nurse Case Manager will initiate member contact and begin the assessment process.</p> <p><i>Motherhood MattersSM Referrals</i>—Abri's <i>Motherhood MattersSM</i> Pregnancy Health Management Program includes a risk assessment and other reports that identify women in a high risk status including the zip code in which the woman resides. Women who are eligible to enroll in the Medical Home pilot will be contacted by phone, informed about the program, and encouraged to participate.</p> <p>Member Awareness—Abri will promote <i>Motherhood MattersSM</i> and the Medical Home pilot to members through program brochures in New Member Welcome Packets, other member mailings, member newsletters, the New Member Welcome Call, health fairs, posters and brochures placed in practitioner's offices, marketing materials, and collaboration with national and local community-based entities. Members may self refer into the program</p> <p>Provider Awareness—Abri will inform physicians of services through their orientation materials, contacts with Provider Service Representatives, the physician newsletter and other written materials, and the Abri Website.</p> <p>Provider Incentives—Abri will encourage provider referral through the use of monetary incentives for completion and return of HMO Perinatal Collaborative Pregnancy Notification Forms: \$25 per form for those indicating women in their first trimester, \$15 for those indicating women in their second trimester, and \$5 for those indicating women in their third trimester.</p> <p>Community Referrals—Abri will encourage community organizations to refer women who may be eligible for the Medical Home pilot, and promote the pilot through ongoing collaboration with community organizations (e.g., Milwaukee Community Tobacco Free Coalition, Wisconsin Diabetes Quality Improvement Project, Statewide Advisory Committee on Eliminating Racial and Ethnic Disparities in Birth Outcomes, Healthy Birth Outcomes Evidence-Based Practices Workgroup, and the Wisconsin Association for Perinatal Care).</p> <p>Utilization Management Referrals—Abri will identify members as a result of admission for complications of pregnancy, requests for authorization or triage service calls</p> <p>Enrollment Information—Abri will identify pregnant members as a result of enrollment due to pregnancy.</p> <p>Other Sources—Abri will also identify women who are potentially eligible for the Medical Home pilot by reviewing reports on, pharmacy utilization data (e.g., prenatal vitamin prescriptions), claim data (e.g., pregnancy lab work or related diagnosis) or physician referral, Nurse Advice Line referrals, and health risk assessments. All welcome calls include a health risk assessment</p>

screening for pregnancy and all chronic conditions listed in the Medical Home pilot section of the DHS contract. If a pregnancy is identified, appropriate follow up questions including due date and Doctor will be asked. The health risk assessment findings will be forwarded to the appropriate staff. All newly identified pregnant women will be contacted by phone within 72 hours of referral by an Abri prenatal team member to emphasize the importance of early prenatal care and introduce the Motherhood MattersSM program. Once initially contacted, a health assessment will be performed. Risk factors will be identified and the member will be stratified to the appropriate level of care, including eligibility for enrollment in the Medical Home pilot.

#### Columbia St. Mary's

Patients will be identified through diagnosis of pregnancy at the clinic visit or through self-referral, and/or urgent/ED visit. Confirmation of pregnancy will be confirmed at the first clinic visit. Identification to qualify for the Medical Home pilot will occur during the first clinic visit.

#### LifeTime OB/GYN

As patients telephone in for appointment at the Clinic, a brief checklist will be completed to preliminarily identify those patients meeting the pilot criteria. Patients who qualify with any 2 required criteria will be referred an OB-team member for further review for eligibility.

#### 16<sup>th</sup> Street

Pregnant patients are identified through diagnosis of pregnancy at a medical clinic visit or through self-referral from the community. Self-referral is done mostly through word of mouth and reputation. Identification of patients as qualified to be a part of the OB Medical Home pilot will happen through the initial OB visit or through the initial OB-case manager interview.

#### Wheaton Franciscan

There are several ways that women present for prenatal care. We are currently running a pilot program that coordinates care for women that present to St. Joseph ED without an established OB-provider. Since the beginning of this pilot we have increased the number of women that initiate prenatal care before 15 weeks from 41% to 54%. We are in year two of the pilot and we are beginning to reach out to other Wheaton EDs that might see pregnant women. We also have a very close relationship with the labor and delivery triage area at St. Joseph. Some of these women will be eligible for the Medical Home pilot program if the restrictions of enrollment are eased. Many of our women come to us from word of mouth or through their own experiences. 45% of our pregnant women were seen in the clinic at some time before they began their pregnancies. All new OB patient charts are reviewed in a multidisciplinary case conference held weekly and every chart is reviewed by the CNM in the clinic after each visit. Identifying patients that can be included in the Medical Home pilot will be fairly easy to accomplish within a few days of beginning care in the clinic.

#### Abri

- The same activities above will introduce members to the pilot through:
- Communication with HMO staff during member contact during routine calls, outreach calls, and welcome calls with or without a health risk assessment.
  - Flyers distribution by HMO staff, site staff, and by physicians in the office to pregnant women.

2. Describe how the Medical Home pilot will be communicated to the member.

**Columbia St. Mary's**

Clinic will provide both verbal and written documentation of the pilot program at time of visit. This information will also be available on the website.

**LifeTime OB/GYN**

An OB-team member (MD, Nurse/MA, or PNCC) will provide patient with verbal and written information at the time of the first clinic visit.

**16<sup>th</sup> Street**

**SSCHC** is able to distribute information to the patient about the pilot program. We would like this to be the same materials for every patient.

**Wheaton Franciscan**

After appropriate scripting, the social worker, registered nurses, PNCC, or provider will describe the Medical Home pilot and benefits to the patient. Once the patient has been identified, it will become someone's responsibility to communicate with the patient in regards to the Medical Home pilot program. The responsibility will fall on the NP/CNM to make sure identified patients are informed of the Medical Home pilot program.

3. Describe who will perform the outreach.

**A bri**  
An Abri Health Promotion Outreach Specialist will call the member to introduce the program and provide information on the benefits of the program for her and her unborn child. If the member could not be reached by phone, a letter with the same information will be sent with an invitation to call a Health Promotion Outreach Specialist at Abri.

**Columbia St. Mary's**

Information about the program will be given to our Nurse Helpline program and/or our MD referral line.

**LifeTime OB/GYN**

At our Offices: posters and general informational materials provided to us by the HMO will be made available to all patients. Patients who qualify for the Medical Home pilot program will be individually counseled by the OB-team and encouraged to participate.

**16<sup>th</sup> Street**

**Abri Health Plan** will perform initial outreach. Following HMO outreach, SSCHC is able to accept referrals of pregnant women. While we have capacity issues at times for adult patients, we are always open to new OB patients.

<p><b>Wheaton Franciscan</b></p> <p>We have several avenues of outreach in the city. As previously stated, we have developed a close relationship with the St. Joseph ED and L&amp;D triage areas. We also have a strong word of mouth following. Many of our patients are friends or sisters of other patients. Our social workers and PNCCs have many relationships in the community. We receive patients from other providers in the community that do not feel capable of handling many of our patient's high medical and psycho-social risks. We work with and receive referrals from the Milwaukee County Jail, the Black Health Coalition, and the African American Breastfeeding Alliance. The clinic also does outreach at community events such as high school career fairs. We also have strong relationships with the public health department. The clinic CNM is an active participant on the Fetal/Infant Mortality Board and works closely with many other community stakeholders to decrease fetal/infant mortality.</p>	<p><b>Abri</b></p> <p>As a part of the outreach and retention strategy Abri will collaborate with community groups and resource agencies such as the HOPE Network and local WIC Sites. Additional ongoing collaboration with community organizations such as the Milwaukee Community Tobacco Free Coalition, the Wisconsin Diabetes Quality Improvement Project, the Statewide Advisory Committee on Eliminating Racial and Ethnic Disparities in Birth Outcomes, the Healthy Birth Outcomes Evidence-Based Practices Workgroup, The Lifecourse Initiative for Healthy Families, AWHONN, and the Wisconsin Association for Perinatal Care will further promote the Medical Home pilot program. As more partnerships develop within the community, more collaboration will occur. The goal is to have a broad base of support, resources, and community groups available to our members to increase outreach efforts and promote member retention. Abri will continue to be an active participant in the HMO Collaborative Groups.</p>	<p><b>4. Describe how the HMO will collaborate with existing community groups and other stakeholders as part of their outreach strategy.</b></p> <p>The Medical Home pilot program will be explained to members during outreach. Once a member agrees to be in the program, each Medical Home pilot site will implement their plan in place in order to communicate the Medical Home pilot practice concept and details. This includes giving contact information, phone numbers, and the e-mail address of the case manager at the Health Plan. Verbal and written materials created jointly by the Health Plan and the Medical Home pilot sites will also be used.</p> <p><b>Columbia St. Mary's</b></p> <p>Patients receive information about the clinic at the time of their initial visit. Verbal and written information is provided at the end of the visit and as needed.</p>	<p><b>LifeTime OB/GYN</b></p> <p>Patients will be presented with all needed information verbally and with written instructions during their first clinic visit. Afterhours-care and contact information is given verbally by the physician and reinforced by care team members. Reinforcement is given as needed during all subsequent visits and phone calls.</p> <p><b>16<sup>th</sup> Street</b></p> <p>Patients receive information about use of our clinic through written materials distributed to each patient. Pregnant patients also have access to services and information through the OB-case managers.</p>
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	<b>Wheaton Franciscan</b> All patients receive information verbally several times during their pregnancy on clinic hours, when to call, and how to get medical help after hours. Each patient will receive a pre-printed appointment card with access information and danger signs. All disciplines in the clinic take responsibility for keeping patients informed of this important information.	
<b>Member Retention</b>	<p>1. Describe how the HMO will retain members within the Medical Home.</p> <p>2. Describe how the HMO will ensure that members keep and attend appointments.</p> <p>3. Describe how the Medical Home will encourage members to follow a treatment plan throughout the pregnancy.</p>	<p><b>Member retention activities will be a collaborative effort of both the HMO and the Medical Home pilot sites.</b></p> <p><b>Abri</b></p> <p>Abri will use the following strategies to retain members in the Medical Home pilot:</p> <ul style="list-style-type: none"> <li>• Member Incentives—Abri will offer member incentives for participation in the Medical Home pilot, which will be provided after completion of various stages during their enrollment. The incentives are designed to keep members motivated to continue to participate, with a final incentive at the end for successful completion. Members will be offered relevant and needed incentives based on compliance throughout the program, this includes attending prenatal visits, going to WIC appointments, and attending educational group meetings. Incentives will be offered through the 60 day postpartum period to further promote compliance and completion of the program.</li> <li>• Peer Support—Women enrolled in the Medical Home pilot will have the opportunity to attend a quarterly educational group meeting with a Nurse Case Manager. During these meetings, members will experience some group activities related to self care and child care. Abri will provide transportation and refreshments. Small gift items will be given to encourage participation. If the Medical Home site agrees to conduct a Centering Pregnancy program, this strategy will be switched to full centering to encourage compliance.</li> <li>• Women in the Medical Home pilot will be enrolled in <i>Motherhood Matters</i>SM Pregnancy Health Management Program. This program has staff available to answer questions, provide learning materials, offer community resources and support all of which are necessary for a healthy pregnancy and a healthy baby. If the Medical Home site agrees to conduct a Centering Pregnancy program, this strategy will be switched to full centering to encourage compliance.</li> <li>• Case Management — Women in the Medical Home pilot will be offered registered nurse case management services which will include assessment of needs, an individualized care plan, ongoing support and education along with coordination of services. The case manager collaborates with the member in implementing a self management plan, which addresses adherence with the treatment plan.</li> <li>• Baby Shower—Abri will host a group baby shower for women in the Medical Home pilot. Members will receive gifts for their baby, gifts for themselves, and they will be entered into a free raffle for larger childcare items based on compliance throughout the program. Refreshments and transportation will be provided. Educational materials and community resources will also be available at the baby shower. Members will be invited to attend one of the baby showers based on the date of enrollment. If the member enrolled:</li> </ul>

Before June 1, 2011, she will be invited to attend the baby shower at the end of June, 2011. June 2, 2011 to December 1, 2011, she will be invited to attend the baby shower at the end of December, 2011.

December 2, 2011 to June 1, 2012, she will be invited to attend the baby shower at the end of June, 2012. June 2, 2012 to December 1, 2012, she will be invited to attend the baby shower at the end of December, 2012.

December 2, 2012 to June 1, 2013, she will be invited to attend the baby shower at the end of June, 2013. June 2, 2013 to December 1, 2013 she will be invited to attend the baby shower at the end of December, 2013.

The woman does not need to be present to win. Each woman that completes her postpartum visit and remains enrolled in the Medical Home pilot for 60 days postpartum will receive additional diapers, wipes, and baby supplies.

- In effort to reduce no show visits, Abri will offer transportation to appointments for members enrolled in the Medical Home pilot if needed. Each site also has a plan in place to reduce the number of no show visits including appointment reminder calls and follow-up calls for missed appointments. Members will be reminded on a regular basis that compliance throughout the duration of the program will help them earn rewards.

#### Columbia St. Mary's

Based on additional FTE approval, the Perinatal Case Manager will contact patients prior to appointments and will follow-up with patients who miss an appointment. As part of the clinic visit, patients will be educated on the importance of keeping appointments and its impact on having a healthy baby. There are group classes offered for the mothers that allow for support and continued education.

#### LifeTime OB/GYN

When a member misses an appointment, the site will inform the HMO allowing for appropriate follow-up to be done. Utilizing incentives provided by the HMO as well as educating the member as to the importance of plan compliance will encourage member retention and follow through.

#### 16<sup>th</sup> Street

OB-Case Manager will be available to make a reminder phone call to each patient prior to her appointment, and to follow up on any no-show appointments. Our Centering Pregnancy program will be an excellent vehicle to address educational needs and encourage follow through. In this program, patient education is self-led, such that the patients identify topics they'd like to learn more about, in addition to the curriculum content designed for each month of pregnancy. The group dynamics developed will encourage follow through. OB-case managers will be available for education and support as well.

**Wheaton Franciscan**

The clinic already has several ways to ensure visits are kept. We do reminder calls for all patient appointments. Patients that 'no show' are called by an RN and reminded of how important appointments are and she is offered an appointment within the next few days.

Many times this appointment is the next day. We also have an incentive program collaborating with the March of Dimes and the Zeta Phi Beta Sorority that provides baby items in exchange for coming to visits and following through on care plans. Patients receive 'points' for coming to visits and participating in a variety of learning opportunities. In exchange for the points, they can go shopping in the Stork's Nest and 'buy' baby items. The average number of visits for pregnant women in our clinic is 10 for the pregnancy.

We also are completely flexible when it comes to meeting patient needs for appointments. We do not refuse to see patients that come late and we work very hard to keep patient wait times to a minimum to encourage compliance. We also run an evening clinic one night a week to accommodate teens that are in school and working moms. We encourage women to come to their first visit by offering them a pack of diapers for their new baby.

The clinic also has created a very caring and accepting atmosphere. Patients know they will not be judged for being late or for missing an appointment. Nothing but praise is offered when patients come to their appointments and follow through on their care plans.

RNs have created a comprehensive teaching care plan that follows the patients through their entire pregnancy (more opportunities for points). Each patient sees the social worker at least twice during her pregnancy; however the social worker is available at every appointment if needed.

**Abri**

As a part of the outreach and retention strategy Abri will collaborate with community groups and resource agencies such as The HOPE Network and local WIC Sites. Additional ongoing collaboration with community organizations such as the Milwaukee Community Tobacco Free Coalition, the Wisconsin Diabetes Quality Improvement Project, the Statewide Advisory Committee on Eliminating Racial and Ethnic Disparities in Birth Outcomes, the Healthy Birth Outcomes Evidence-Based Practices Workgroup, The Lifecourse Initiative for Healthy Families, AWHONN, and the Wisconsin Association for Perinatal Care will further promote the Medical Home pilot program. As more partnerships develop within the community, more collaboration will occur. The goal is to have a broad base of support, resources, and community groups available to our members to increase outreach efforts and promote member retention. Abri will continue to be an active participant in the HMO Collaborative Groups.

**Columbia St. Mary's**

Rapport will be established at the first clinic visit and will continue throughout the duration of the pregnancy. Understanding, listening, and follow through from the medical team will be important in keeping the patient engaged. Education of healthy habits at the mother's cultural and psychosocial level will influence ongoing rapport. Earning the mother's trust through communication will be key in developing relationships.

**LifeTime OB/GYN**

Our one doctor/one nurse approach and our organizational workflow throughout the clinic will help to establish a close and trusting relationship with all of our patients.

4. Describe how the HMO will collaborate with existing community groups and other stakeholders as part of their member retention strategy.

5. Describe how the care coordinator and Medical home staff will establish a rapport with members.

**16<sup>th</sup> Street**

OB-case manager performs an initial intake visit either in person or over the phone. Based on the requirements of this pilot project, ongoing rapport will be maintained through monthly home visits. If it is possible to substitute, the Centering Pregnancy program would also work to build rapport and open communication with the patients.

**Wheaton Franciscan**

Our care coordinators and clinic staff have already created rapport with our patients. We work together as a team to meet our patients' needs. We meet in the beginning of each patient's care for a multidisciplinary case conference and a care conference meeting is also held in third trimester to review all charts and make sure that education and medical plans have been completed.

6. If a member misses an appointment, describe the follow-up procedures that the Medical home and/or the HMO will engage in step-by-step.

**Abri and All Medical Home Pilot Sites**

Follow-up procedures for missed appointments will be a collaborative effort between both the HMO and the Medical Home pilot sites.

No show information will be communicated from the site to Abri through open communication and information sharing. The member will receive a call from either the HMO or the site. The person calling will inquire about the cause. If the reason is the result of some barrier such as lack of transportation, language issues or other, the care coordinator will work with the member to eliminate the barrier. If the reason is a prevailing social service issue, the care coordinator will refer the member to the appropriate internal or external resources to help alleviate the issue. Regardless of the reason, the care coordinator will schedule another appointment with the member and put the no show reduction strategy techniques mentioned earlier into place to assist the member in keeping her appointment. Education will be provided on the importance of keeping visits. Positive feedback will be given at the next visit. If the member cannot be reached by phone a follow-up post card or mailing will be sent.

**OB First Contact of Care**

1. Describe in detail how the OB-Care provider will function as the first contact of care or point of entry for the member.

**Columbia St. Mary's**

Prenatal care is initiated upon diagnosis of pregnancy or through a patient call. An appointment is made with the OB-care provider. At the initial appointment, a "new OB" history and physical exam is obtained.

**LifeTime OB/GYN**

The OB-care provider and Nurse will identify patients who are eligible for the on her first visit. The patient will be counseled about the Medical Home pilot program and asked if she would like to join. Specific needs will be assessed by care team and recommendations and/or referrals will be made as necessary. Each patient who wishes to enter will be clearly identified within the practice for all care providers. The "Risk Factors Identified" section of the prenatal record will be marked to indicate enrollment.

**16<sup>th</sup> Street**

Upon diagnosis of pregnancy or through a patient call, an appointment is made with the OB-care provider. At the initial

<p>appointment, a “new OB” history and physical exam is obtained and prenatal care is initiated.</p> <p><b>Wheaton Franciscan</b></p> <p>The OB-provider may not be the first person a patient sees in the clinic. Since we require no proof of insurance, we often times have women come in to see the financial counselor or social worker to help begin the insurance process. Patients that request care in the clinic will have an appointment with the RN and MD within 7-10 days of initial contact. However, there is always a provider or RN available to the social workers and PNCCs if they require any medical assistance when meeting with a patient.</p>	<p><b>2. Describe how the Medical home team (clinical staff, nurses, lead OB-care provider, and other providers) will function.</b></p> <p><b>Columbia St. Mary's</b></p> <p>One medical provider, either a resident or faculty member, assumes primary responsibility for the patient's care during pregnancy. Every attempt is made to make appointments with the primary provider throughout the duration of the pregnancy and postpartum period. The Case Manager works with all providers, and helps ensure that the patient has access to ancillaries such as a lactation specialist as needed.</p> <p><b>LifeTime OB/GYN</b></p> <p>One Obstetrician is responsible for the care of the pregnancy and postpartum patient. Each physician has a dedicated nurse who interacts with both the patient and the physician to coordinate care. Additional clinical staff and resources will be involved as needed. The prenatal flow sheet will be used for documentation by all clinical team members.</p> <p><b>16<sup>th</sup> Street</b></p> <p>One medical provider, either a CNM or a FP Physician, assumes primary responsibility for the patient's care during pregnancy. Every attempt is made to make appointments with the primary provider throughout the duration of the pregnancy and the postpartum periods. Our OB-Case Managers interact with all of our OB-care providers. We also provide assistance with lactation consultation.</p> <p><b>Wheaton Franciscan</b></p> <p>The CNM or NP in the clinic will take responsibility for making sure that all care plans are established and followed through. Most high risk women see a resident physician in conjunction with the CNM or NP and consultation with a maternal fetal medicine MD as needed. While resident physicians may rotate through the clinic, the CNMs and NPs are stable and provide continuity of care.</p> <p>Through a very comprehensive program, OB-case managers, social workers, RNs and all providers work together and communicate through verbal and written means to provide care to our very complex patients.</p>	<p><b>Written Standards for Access and Communication</b></p> <p><b>1. Describe the written access standards that the Medical Home will adopt. Include appointment wait time standards.</b></p> <p><b>Abri</b></p> <p>For women with high-risk pregnancies, timely access to services can be the difference between a healthy birth outcome and complications that have long-term consequences for the mother, child, and health system overall. Abri has confirmed that its Medical Home pilot partner clinic(s) possesses the capacity to handle the number of women proposed for enrollment in the pilot. Abri will routinely monitor access to care in the pilot to ensure that it meets standards established by the Department of</p>
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<p>Health Services (DHS). Providers encountering difficulty with obtaining specialty care will be able to rely on assistance from Abri. In extreme cases, Abri's provider relations experts may be called upon for assistance to ensure access.</p>	<p>Abri will adopt written standards for patient access described in the BadgerCare Plus Contract in Article II, H of (e.g., no longer than 14 days for an appointment with a PCP and no longer than 10 days for an appointment with a mental health provider to receive an initial assessment). Members in the Medical Home pilot will have access to treatment and/or medical advice 24 hours a day, seven days a week through their Medical Home site and Abri's Nurse Advice Line.</p> <p>Each site has established policies and procedures regarding appointment scheduling, wait times, and telephone call back responses. The specifics of each site's policy and procedure are tailored to meet the needs and demands of their patient population. Each site's implemented policy and procedure, along with their patient service philosophy, defines how new patients will be scheduled, how urgent care needs will be addressed, what an acceptable wait time to access quality services is, and how to coordinate walk-in appointments with scheduled visits. Although the specifics of the policy and procedure are different for each site, patient's needs are met on a daily basis and a high level of quality care continues to be provided by all of the sites.</p>	<p>Meeting the requirement for providing treatment and/or medical advice 24/7 will be a collaborative effort between the HMO and Medical Home pilot sites. Although the above standards do not provide 24/7 care, on-call staffing policy and procedures and emergency room services and urgent care services do meet this requirement.</p>
	<p><b>2. Describe how these standards will meet the requirements that treatment and/or medical advice will be available 24/7.</b></p>	<p><b>Abri</b> In addition to the 24/7 care offered through each Medical Home pilot site, Abri Health Plan will offer a supplemental 24 hour Nurse Advice Line that delivers comprehensive, personalized, and non-clinical telephone services while respecting cultural diversity through immediate health care advice and education. This service provides members with 24-hour direct access to health care professionals fluent in English and Spanish. Abri Health Plan members will have use of Urgent Care Facilities, as specified in individual contracts, and Emergency Room Services.</p>
		<p><b>Columbia St. Mary's</b> Clinicians are available 24/7. When the clinic is open, patients can talk to a member of the healthcare team. After hours, providers are available to take call for patients. Instructions on how to reach a provider after hours are provided at the initial visit and are reviewed at subsequent visits.</p> <p><b>LifeTime OB/GYN</b> Access to treatment and/or medical advice 24/7 is achieved by the use of an answering service and by having a physician on call during the hours the clinic is closed. During clinic hours patients may speak with their nurse/physician/care coordinator.</p> <p><b>16<sup>th</sup> Street</b> Our clinicians are available 24/7. When the clinic is open, patients are able to talk with an OB-Case Manager or with a member of the OB-care clinician medical team. After the clinic is closed, our providers take call for all of our patients. Through</p>

our central phone number, patients are able to talk with our on-call provider. These instructions are provided to the patient in our written materials.

#### Wheaton Franciscan

Physicians are available 24/7. Patients receive information on how to access an MD anytime the clinic is not open. There are always physicians in the hospital from the clinic and we have a system of documenting all patient phone calls during off hours to make sure they are recorded in the patient chart.

Patients have access to a Registered Nurse during clinic hours. Calls are triaged and those that are emergent are handled accordingly. The RN always has access to CNM, NP or MDs as needed.

Patients receive a pre-printed appointment card with information on how to get a hold of a health care provider at any time. Cards are in English and Spanish. Women who speak other languages have an interpreter at their appointments who can write the information in their language.

Our phone system is set up to allow women to get the hospital operator by pushing 0. Even women that don't speak English can easily access the operator. Women are instructed how to share their language needs with whomever answers the phone and that person knows how to get the appropriate interpreter on the line. All of our secretarial staff speaks English and Spanish.

3. Describe how ED use by the member will be addressed, including procedures that the Medical home will engage in when an ED visit by the member occurs.

Addressing member ED use will be a collaborative effort by both the HMO and the Medical Home pilot sites.

#### Abri

Member ED use will be addressed according to the ED UM program. In addition, each Medical Home pilot site has its own procedure in place to address ED use.

#### Columbia St. Mary's

Columbia-St Mary's has an urgent care clinic that patients can access. CSM has ED case managers who educate patients on importance of follow-up visits and when to use urgent care or the ED. CSM ED case managers follow up with the clinic if any of their patients have been seen and what information was provided. If needed, the ED case managers can assist in scheduling follow-up clinic visits at the time of the ED or urgent care visit.

#### LifeTime OB/GYN

Patients with urgent needs are seen in the office or directed to the Labor and Delivery triage area of the hospital where patient plans to deliver. Patients are given instructions for accessing emergency care as part of their prenatal care and counseling. When a patient visits the ED, reinforcement of preferred procedures will be reiterated during subsequent patient encounters with the OB-care team.

#### 16<sup>th</sup> Street

SSCHC Urgent Care Clinic is available to our patients from 8:30 am to 8:30 pm, Monday through Friday. Patients with urgent needs are able to be seen through the clinic or through walk-in appointments as needed.

If SSCHC is aware that an ER visit has occurred, an OB-case manager will call the patient to provide education on appropriate use of the ER, clinic access policies, and other education as needed.

#### Wheaton Franciscan

We encourage patients to come to the clinic during normal clinic hours unless we deem the problem to be something that cannot be dealt with safely in an outpatient setting. We have same day and next day appointments and have created a system that allows us flexibility in the clinic for walk-ins and triage calls. Having an RN available to educate and help women care for themselves has been instrumental in decreasing ED use.

Women are also encouraged to call at night. Our MDs in the hospital have access to patient information and can help the patient make safe choices for staying home and coming in the next day. MDs merely leave a voice mail on a specially designated line with patient name and identifying info, phone number to reach patient at, problem and recommended visit time. The triage nurse listens to all messages at 8:00 and calls patients to help them come into the clinic ASAP.

<p>4. Describe how the HMO and clinic will meet the NCQA standard of providing same day appointments for routine and urgent care based on the practice's triage of patients.</p>	<p>Abri will monitor the sites' compliance with their written policy and procedure to ensure same day appointments for routine and urgent care are being followed.</p> <p>Each site's policy and procedure addresses and allows for same day appointments to be scheduled based on need after triage by an RN or the OB-care provider. The established policies and procedures also address appointment scheduling, waiting times, and telephone call back responses. Although the specifics of the policy and procedure are different for each site, patient's needs are met on a daily basis and a high level of quality care continues to be provided by all the sites.</p>	<p>5. How will you address and evaluate the relationship between providers and HMOs?</p> <p><u>Abri</u> All four HMOs are currently collaborating together and with the Medical Home pilot sites in order to</p> <ul style="list-style-type: none"> <li>• Facilitate effective communication</li> <li>• Measure outcomes</li> <li>• Streamline procedures</li> <li>• Reduce barriers</li> </ul> <p>Success of a quality relationship will be determined by the degree of collaboration and communication, the information sharing, the coordination of resources between the plan and the site, and through healthy birth outcomes.</p>	<p><b>Electronic Health Records</b></p> <p>1. Describe the type of electronic health records that will be used.</p> <p>3. Include the product name of <u>Columbia St. Mary's</u></p> <p><u>Abri</u> Abri case management staff utilizes an information system which provides evidenced based assessment and care planning tools.</p>
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the electronic health record system that will be used	<p>EHR not available at the OB clinic, data will be extracted from medical records to Excel</p> <p><b>LifeTime OB/GYN</b></p> <p>LifeTime OB/GYN, Ltd. uses a paper medical record but has access to the Intelligent Healthcare Registry from which data can be inputted and extracted including billing and lab data. Additionally, Excel Spreadsheets can be utilized as appropriate.</p>
<p><b>16<sup>th</sup> Street</b></p> <p>SSCHC uses an electronic medical record system by Sage, called Intergy. It contains a module specific to OB care, called OB chart. The charting within this module is designed for monthly ROB visits, as well as the tracking of labs, physical exam data, ect.</p>	<p><b>Wheaton Franciscan</b></p> <p>Wheaton Franciscan Healthcare St. Joseph uses an electronic system for storing patient information.</p> <p>All labs, ultrasounds, consult and ED visits done within the system can be accessed 24/7. All written materials are scanned into the digital record and are also available electronically.</p> <p>2. List the information that will be available to the clinic through this system.</p>
<p><b>Implement Evidence-Based Practices</b></p> <ol style="list-style-type: none"> <li>1. List all nationally recognized evidence based guidelines (e.g. ACOG, CDC) for chronic disease and pregnancy that will be adopted by the Medical Home for the conditions listed under R2d.</li> </ol>	<p>All elements required in a history and physical examination and those necessary to conduct and document related care activities are available to the clinics through the systems they utilize. This information makes up the entire patient OB Chart. Each site will be responsible for recording key data elements in a database. This database will then be shared with Abri, allowing for result tracking and outcome identification.</p> <p>Abri will support each of the recognized guidelines the sites use for medical management. If the site does not have evidence based guidelines in place, Abri will utilize the Disease Management program to supplement medical management.</p> <p><u>Columbia St. Mary's</u></p> <p>OB: ACOG Prenatal Care guidelines</p> <p>DM: WI diabetes guidelines</p> <p>Asthma: Guidelines from the diagnosis and treatment of asthma, NHLBI</p> <p>Hypertension: Joint National Committee on prevention, detection, evaluation and treatment of high blood pressure</p>
<p><b>LifeTime OB/GYN</b></p> <p>LifeTime OB/GYN (the Medical Home) will adopt all of ACOG's practice guidelines for the management of chronic disease in pregnancy. The ACOG guidelines combine most nationally recognized and published guidelines. Abri will utilize the Disease Management program to supplement medical management.</p> <p><b>16<sup>th</sup> Street</b></p> <p>OB: Prenatal Care Guidelines. GDM Guidelines</p> <p>DM: Wisconsin Diabetes Guidelines</p> <p>Asthma: Guidelines for the Diagnosis and Management of Asthma, NHLBI</p>	<p>Abri Health Plan, Inc 12/27/2010</p> <p>Page 15</p>

	Hypertension: Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7)
<b>Wheaton Franciscan</b> ACOG guidelines	<p><b>Abri</b> As part of Abri Health Plan's quality review plan, activities such as chart review, auditing, data evaluation and outcome evaluation will take place.</p> <p>3. Abri and the partner Medical Home pilot sites will collaborate to address the complex need of women with chronic conditions through:</p> <ul style="list-style-type: none"> <li>• Health Risk Assessments</li> <li>• Education</li> <li>• Stratifying needs to appropriate levels of care through utilization of disease management, case management, and care coordination</li> <li>• Utilizing developed evidenced based assessment tools</li> <li>• Encouraging participation in established programs</li> <li>• Making referrals to community agencies or programs</li> <li>• Promoting self-management</li> <li>• Developing individualized care plans focusing on short term and long term goals</li> <li>• Carrying out interventions necessary to achieve goals identified in care plans</li> <li>• Evaluating interventions, documenting progress, and adjusting care plans as necessary for the member</li> <li>• Addressing the needs of women will be done where and when it is most appropriate, utilizing the proper resources to ensure maximum efficiency and optimal outcomes.</li> </ul> <p>In addition, members enrolled in the Medical home will be enrolled in Abri's <i>Motherhood MattersSM Pregnancy Health Management Program</i>, behavioral health case management (if needed) and an evidence-based disease management program if they have a chronic condition.</p> <p>Members enrolled in the Medical Home pilot will receive specialized case management services that are focused on coordinating care for high-risk pregnancies and reducing poor birth outcomes. All Medical Home pilot participants will be tracked within a single data platform to allow multi-disciplinary team interventions consistent with the Care Management Plan.</p>
2. Describe how the HMO will evaluate and ensure that these guidelines are followed.	
3. List all procedures for addressing the complex needs of women with these chronic conditions.	

<p>4. Include procedures for appropriate referrals and how those procedures meet ACOG guidelines or other national standards.</p>	<p><b>Abri and All Medical Home Pilot Sites</b> Referral procedures are based on ACOG guidelines, thus will meet ACOG guidelines and national standards.</p> <table border="1" data-bbox="393 86 1392 2044"> <thead> <tr> <th colspan="2" data-bbox="393 86 577 2044"><b>Patient Self-Management</b></th></tr> </thead> <tbody> <tr> <td data-bbox="393 86 577 2044"> <p>1. Describe how the Medical Home will engage and educate the member in patient self-management.</p> </td><td data-bbox="577 86 1392 2044"> <p><b>Abri</b> <i>Motherhood Matters</i>SM Pregnancy Health Management Program encourages member self management, active participation in health care, and offers education for the member on various topics. The individualized care plan for members enrolled in case management addresses self management.</p> <p><b>Columbia St. Mary's</b> In the initial visit, patients are given information about the importance of self management. Patients are given techniques and strategies to help them. Consideration of cultural and psychosocial aspects is included to improve compliance.</p> <p><b>LifeTime OB/GYN</b> LifeTime OB/GYN places emphasis on education and use of all pertinent materials available. Additional referrals to community organizations are used as appropriate, for example Rosalie Manor for teen parents support. Each OB patient is presented with a wide variety of written materials on the first visit.</p> <p><b>16<sup>th</sup> Street</b> Our preferred method of engagement is our Centering Pregnancy program. This program emphasizes self-management. It is group directed, focusing on education. Patients are taught self-management techniques and strategies.</p> <p><b>Wheaton Franciscan</b> The RNs, PNCCCs, and Social Workers have created specific teaching plans that address specific barriers and problems in our community. Smoking cessation, breastfeeding initiation, marijuana reduction, and diabetes management are all examples of the types of education that our RN, PNCCCs, and SWs engage in. We have several ways to encourage self management including patient driven education. We have surveyed our entire population of OB patients several times in the last few years to allow them the opportunity to tell us what they need to learn and how they would like to learn. Patients also have the option of self-educating with several culturally competent and health literate DVDs and classes. If the patient decides to participate in the self-education option, she can receive storks nest points.</p> </td></tr> </tbody> </table>	<b>Patient Self-Management</b>		<p>1. Describe how the Medical Home will engage and educate the member in patient self-management.</p>	<p><b>Abri</b> <i>Motherhood Matters</i>SM Pregnancy Health Management Program encourages member self management, active participation in health care, and offers education for the member on various topics. The individualized care plan for members enrolled in case management addresses self management.</p> <p><b>Columbia St. Mary's</b> In the initial visit, patients are given information about the importance of self management. Patients are given techniques and strategies to help them. Consideration of cultural and psychosocial aspects is included to improve compliance.</p> <p><b>LifeTime OB/GYN</b> LifeTime OB/GYN places emphasis on education and use of all pertinent materials available. Additional referrals to community organizations are used as appropriate, for example Rosalie Manor for teen parents support. Each OB patient is presented with a wide variety of written materials on the first visit.</p> <p><b>16<sup>th</sup> Street</b> Our preferred method of engagement is our Centering Pregnancy program. This program emphasizes self-management. It is group directed, focusing on education. Patients are taught self-management techniques and strategies.</p> <p><b>Wheaton Franciscan</b> The RNs, PNCCCs, and Social Workers have created specific teaching plans that address specific barriers and problems in our community. Smoking cessation, breastfeeding initiation, marijuana reduction, and diabetes management are all examples of the types of education that our RN, PNCCCs, and SWs engage in. We have several ways to encourage self management including patient driven education. We have surveyed our entire population of OB patients several times in the last few years to allow them the opportunity to tell us what they need to learn and how they would like to learn. Patients also have the option of self-educating with several culturally competent and health literate DVDs and classes. If the patient decides to participate in the self-education option, she can receive storks nest points.</p>
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	<p>We track outcomes consistently and participate in program evaluation. Specific examples of what is tracked and how it is tracked is available to the HMO if they would like to see the information.</p>
2. Describe any member incentives that will be used for the member to engage in patient self-management, if any.	<p><b>Abri</b> See the member Retention Strategy above. Specific member incentives will include gift cards and child care items and supplies.</p>
3. Provide or describe any tools or educational materials that will be used in the patient self-management strategy.	<p><b>Abri</b> Educational materials and handouts will be provided for the member through the <i>Motherhood MattersSM</i> Pregnancy Health Management Program. Materials and handouts focus on various topics including self-care, caring for a baby, health promotion concepts, and patient self-management education.</p> <p><b>Columbia St. Mary's</b> OB educational materials are specific to the month of pregnancy the patient is in. Other topics related to pregnancy include breast feeding, care of baby, safe sleep, and birth control.</p> <p><b>LifeTime OB/GYN</b> OB education booklets distributed by WFHC and WAMH are available as well as various brochures and pamphlets that discuss a broad range of obstetric topics. All materials developed by the HMO for use with the Medical Home pilot program will be distributed at our site to our patients.</p> <p><b>16<sup>th</sup> Street</b> The OB education booklet distributed by CSM is available in addition to our Centering Pregnancy materials. Information is also available on birth control and other educational topics.</p> <p><b>Wheaton Franciscan</b> We have a plethora of culturally competent and health literate written materials, videos, group classes for breastfeeding, and one-on-one sessions with an RN. These materials are in English and Spanish and we use interpreters for other languages. We have created our own resource guide for MDs and patients in a very health literate manner in English. We are working to have the resource guide translated to Spanish. We only utilize material that our own committee has reviewed to ensure it is culturally competent, accurate and health literate before giving it to our patients. We are creating a process that will allow our patients to contribute their thoughts to the materials we use. We will continue to utilize survey tools for evaluation.</p>

<p><b>1. List and describe all measures that the HMO will measure the Medical Home and individual physicians on.</b></p>	<p><b>Abri</b> To evaluate the Medical Home and individual physicians, the following measures will be used:</p> <ul style="list-style-type: none"> <li>1. HEDIS® Prenatal and Postpartum rates.</li> <li>2. HEDIS® Frequency of Ongoing Prenatal care</li> <li>3. Percentage of participants with completed prenatal screening assessment prior to delivery.</li> <li>4. Percentage of participants who had a poor birth outcome and did not receive satisfactory care.</li> <li>5. Member satisfaction with the program.</li> <li>6. Percentage of participants with completed prenatal screening assessment prior to delivery.</li> <li>6. Percentage of participants who had a poor birth outcome and did not receive satisfactory care.</li> </ul>
<p><b>2. Explain why these set of measures are the most appropriate to measure the effectiveness of the Medical Home and the individual physicians.</b></p>	<p><b>Abri</b> First and foremost they are the required measures provided in the DHS contract or by RFP response. HEDIS and CAHPS are nationally recognized measures of quality.</p>
<p><b>3. Describe how often the HMO will report on these measures to the Medical Home, physicians, and members, and in what format.</b></p>	<p><b>Abri</b> The Medical Home and its physicians will be presented with progress on the quality measures listed in number one. Members will be informed during the presentation of the Annual Report and on Abri's website.</p>
<p><b>4. Describe the experience and capacity that the HMO has to run these quality measures.</b></p>	<p><b>Abri</b></p>

Performance measures will be collected and reported semi-annually. In addition, an annual program evaluation will be completed and reviewed by the appropriate internal committee for improvement and/or enhancements. To fully evaluate the programs on certain outcomes, a sufficient time-in-place and member volume must be established. Interim and intermediate outcomes will be analyzed until reporting criteria thresholds are achieved.

1. HEDIS® Prenatal and Postpartum rates.
2. HEDIS® Frequency of Ongoing Prenatal care
3. Percentage of participants with completed prenatal screening assessment prior to delivery.
4. Percentage of participants who had a poor birth outcome and did not receive satisfactory care.
5. Member satisfaction with the program.
6. Percentage of participants with completed prenatal screening assessment prior to delivery.
6. Percentage of participants who had a poor birth outcome and did not receive satisfactory care.

Almost all Molina Health Plans are NCQA Certified. Abri will undergo certification at some point in the future. Molina Health Plans are consistently in the top "best quality Medicaid health plans" in the United States as reported in US News & Reports. Molina will monitor the quality of care provided to Members through the Quality Assessment/Performance Improvement (QAPI) program with a multi-dimensional approach. Molina utilizes a systematic collection process to assure valid, reliable and population-appropriate data are reported. Sources used to determine quality of care outcome measures include, but are not limited to the following:

- NCQA® Standards and Guidelines
- HEDIS®/CAHPS® Technical Specifications
- NCQA® Quality Compass

<ul style="list-style-type: none"> <li>• Recommendations and activities from the State of Wisconsin</li> <li>• Abri Standards and Performance Goals</li> <li>• Clinical Standards of Care (e.g., InterQual®)</li> <li>• Industry standards or benchmarks</li> <li>• U.S. Preventive Services Task Force (USPSTF)</li> </ul> <p>Molina currently administers 17 Medicaid and SCHIP programs/contracts in nine states. Molina has cultivated a constructive partnership with State Medicaid agencies that spans over a quarter of a century and extends across all Molina health plans nationwide. Molina believes in the value and wisdom of the Medical Home Model, especially when it is combined with a Chronic Care Model for chronically ill or high-risk populations, including pregnant women. Although not all medical practices can meet the formal requirements of a Medical Home, Molina has been able to work with its network providers to provide many of the more complex services in a way that allows physician practices and clinics to achieve many of the functions associated with a Medical Home.</p>	<p><b>Cultural Competency</b></p> <p>1. Describe how the HMO will ensure that cultural competency will be incorporated within the Medical Home and in the delivery of care to members.</p> <p><u>Abri</u> Abri recognizes that the population it serves is diverse, and responds by monitoring and addressing the special needs of members who are low income or of specific population groups. Abri is committed to the following standards in written policies, administration, and service practice: (1) recognizing members' beliefs, (2) addressing cultural differences in a competent manner, and (3) fostering in staff and provider behaviors that effectively address interpersonal communication styles that respect our members' cultural backgrounds.</p> <p>Molina was founded, organized, and staffed specifically to serve Medicaid and other government sponsored programs in a culturally competent manner. Molina has a long history of providing leadership to advance cultural competence and was a founding member of The National Health Plan Collaborative (NHPC). Established in December 2004, this groundbreaking project brought together 11 major health insurance companies, in partnership with organizations from the public and private sectors, to identify ways to improve the quality of health care for racially and ethnically diverse populations. Together, these member health plans reach more than 87 million Americans. Each Molina plan undergoes a periodic assessment by The Molina Institute for Cultural Competency, a division of Molina Healthcare, Inc. This Institute is a unique resource with years of experience in the evaluation and practical application of cultural concepts that are employee, provider, and member-friendly.</p> <p>Molina is nationally recognized for its leadership in providing advancing cultural competence and will provide Abri with cultural competency and service excellence training for its staff upon hiring and on a periodic basis thereafter. Abri's subcontractors, DentaQuest and Beacon Health Strategies, will further enhance member access to culturally competent staff. Medical Home pilot members with behavioral health needs will have access to Beacon's 200+ staff members who represent 22 different languages.</p> <p>Abri has confirmed that its Medical Home pilot partner clinic(s) will operate their practice in a culturally competent manner. Abri will support the clinic(s) effort by augmenting and providing a range of cultural and linguistic services. For example, Abri</p>
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	<p>Health Plan's Customer Service and Care Management Departments currently include staff members who speak English, Spanish, and Hmong.</p>
2. Describe how members will have appropriate access to interpreter services.	<p>Ensuring access to interpreter services will be a collaborative effort of Abri and the Medical Home pilot sites. In addition to the resources available to members through the Medical Home pilot site, Abri has sufficient resources to satisfy any need in this area.</p> <p><b>Columbia St. Mary's</b> The CSM OB Clinic has Spanish speaking staff, and language services available for other languages not spoken by staff such as Russian and Hmong.</p> <p><b>LifeTime OB/GYN</b> The clinic has a contract with Language Source to provide interpreter service as needed. Members with LEP are identified when the first appointment is scheduled; the interpreter needs are recorded in the patient's record.</p> <p><b>16<sup>th</sup> Street</b> SSCHC has bilingual (Spanish) abilities in all areas of patient flow and care.</p> <p><b>Wheaton Franciscan</b> The clinic has access to a Spanish speaking interpreter during clinic hours and many of our OB-care providers, nurses, social workers, and secretaries speak Spanish. All phones in the clinic are hands free and interpreter ready. We have access to any language through the language line. Women coming in for longer visits such as their first visit or their postpartum visit have an interpreter ordered for them from our language resource center. Approximately 60% of our patients speak English and about 30% speak Spanish. Other spoken languages include Urdu, Arabic, Chinese, Russian, French and several African languages.</p> <p><b>Columbia St. Mary's</b> CSM has an extensive program related to cultural competency. Staffs are required to attend diversity training on an annual basis. In the CSM intranet site, educational materials are provided and can be accessed by staff as appropriate.</p> <p><b>LifeTime OB/GYN</b> Our practice has a diverse patient base built upon 25+ years of serving our community. We have ongoing referral relationships with a culturally diverse population. We believe this serves as testament to the needs of many different peoples and cultures. Our broad experiences are shared within the clinic by physicians and staff members alike to address specific needs of differing cultures. Cultural Competency is regularly addressed with all clinic staff during staff meetings. Additional handouts will be offered for self-study. Outside CME will be utilized as appropriate.</p>
3. Describe the training, policies and procedures that the Medical Home clinic has in place around cultural competency.	

**16<sup>th</sup> Street**

SSCHC lives and breathes cultural competency. The majority of employees live in the community that we serve. Cultural competency is required of all clinicians at recruitment. Periodic CME trainings are provided for clinicians and our staff receives diversity training on an annual basis.

**Wheaton Franciscan**

Wheaton Franciscan Healthcare has an entire cultural competency program that every associate must go through before working in the system.

The clinic has created our own system of learning from our patients and working with each other to provide culturally competent care. It would be virtually impossible for the clinic to be experts in every culture we serve; therefore, we have created an atmosphere where we continually learn about the women and families we serve. We also educate ourselves and each other when we encounter new cultures through journal articles, personal experiences and inviting experts from the community to come in and speak to us.

We hold ourselves to a very high standard in the clinic to meet our patients' needs. We have a diverse population of staff members and we continually try to reflect our patient population. Our philosophy is that our patients are the best teachers of cultural competence and we rely on their needs and expectations to create our processes.

**Abri and All Medical Home Pilot Sites**

Abri and the Medical Home pilot sites will outreach to existing groups for training and/or education as necessary in order to promote cultural competency. Abri and the Medical Home pilot sites are available to meet/speak with representatives of existing groups to better understand the community's needs.

4. Describe how existing groups will be used to promote cultural competency in the Medical Home.

**Care Coordinator****Abri**

- The care coordinator will be responsible for performing activities to promote healthy birth outcomes. Activities include:
1. Assisting the member in making and keeping appointments
  2. Contacting providers and public services as needed
  3. Coordinating services from community programs
  4. Providing patient education
  5. Assisting with other tasks that would help the member have a healthy pregnancy
  6. Contacting the PCP of the member to determine medical history, current conditions, or concerns
  7. Developing a care management plan (OB-Provider with Care Coordinator, PCP and member) with an intake process that identifies needs and includes a self care component
  8. Completing monthly home visits by a nurse or social worker
  9. Tracking progress in care plan
  10. Contacting the PCP to inform him or her of the birth, the outcome, and communicate concerns for member or child
  11. Educating the member on interconception care

	<p>12. Developing a treatment plan for the infant and mother with input from mother and OB-care provider, including coordination of appointments for both</p> <p>13. Maintaining contact with mother to follow up to ensure appointments with other providers are kept</p> <p>14. Following-up with the mother at least twice a year for two years to ensure mother and child are getting proper care</p>	<p>These activities will be performed based on member need and an individualized care plan throughout the duration of the pregnancy and post partum period. Activities of the Site Care Coordinators will be collaborative with Abri Case Managers and Disease Managers. Medical Home Site programs are described throughout this document.</p>
2. Describe what qualifications the Care Coordinator must have.	<p><b>Abri</b> Qualifications for the care coordinator will be based on education, training, and experience relevant to the job. The care coordinator will also need to meet qualifications necessary for employment and uphold the standards of practice.</p>	<p>Patient advocacy activities will be a collaborative effort between the HMO and the Medical Home pilot sites. This will include understanding patients' psychosocial needs, providing support as needed, making referrals to community organizations, utilizing available resources, and developing meaningful partnerships for the benefit of the members. Patients experiencing difficulty accessing quality services will be assisted to navigate the healthcare system and reduce barriers.</p>
3. Describe any patient advocacy activities that the Care Coordinator will engage in.	<p>Discharge Plan</p> <ol style="list-style-type: none"> <li>List all activities to take place for the member and child for the first 60 days postpartum, beginning with the discharge from the hospital following birth.</li> </ol>	<p>Completing activities in the postpartum period will be a collaborative effort of the Health Plan and the Medical Home pilot sites. Abri Health Plan and sites will work together with the member to ensure a transition from the Medical Home pilot into the Health Plan's programs and available resources. Abri Health Plan will continue to provide education, answer questions, utilize open communication with both the member and provider, and focus on continuity of care. The importance of education will be a major focus. This will include information about breastfeeding, safe sleep, smoking cessation, well baby visits, lead testing, immunizations, interconception care, and birth control options. Furthermore, WIC and community agency resource referrals and postpartum depression screenings will be done accordingly. Abri's transitional care program includes contact with the member after delivery to evaluate post discharge needs and encourage care for the mother and baby.</p> <p><b>Columbia St. Mary's</b> At time of discharge, inpatient case managers will make an appointment for follow-up care for both mom and baby. Patients are also given information about expectations once home. The new FTE will call the mothers within 72 hours of discharge and/or next business day to answer questions and/or to identify any issues/support needs of the patient.</p> <p><b>LifeTime OB/GYN</b> Patients are sent home with appropriate community and medical referrals and instructed to return for their postpartum visit with their Obstetrician.</p>

	<b>16<sup>th</sup> Street</b> Each postpartum mother and baby receives a home visit by one of our RN case managers or by one of our OB outreach workers. These staff members assist the mother in the first few days of the postpartum period by providing education as needed, assisting with any concerns about either the mother or baby, and with breastfeeding. These staff members serve as a liaison with the pediatrician and/or the OB-care provider.	
2.	List any postpartum guidelines that will be used by the Medical Home and describe how the HMO will ensure that these guidelines are met.	All Medical Home pilot sites will follow postpartum guidelines according to the contract requirements and ACOG guidelines for appropriate postpartum care. Adherence to these guidelines will be determined by the Health Plan by analyzing claim data and data-element reporting, communicating with the sites and the member, tracking referrals to Beacon Health Strategies for postpartum depression, and through continued education.
3.	Describe how the HMO will transition the member's care to their PCP.	<p><b>Abri</b> Most Medical Home pilot sites have a transition process already included in their program. To supplement, Abri's care coordinator will perform the functions necessary for ensuring continuity of care.</p> <p><b>Columbia St. Mary's</b> During the post partum visit, if not already done, the mother will be provided an appointment with a PMD to ensure continuity of care.</p> <p><b>LifeTime OB/GYN</b> The Health Plan will assume responsibility for care transition as primary care providers are not on site.</p>
		<p><b>16<sup>th</sup> Street</b> At SSCHC, patients are assigned both a midwife and a PCP at entry into care. Once the postpartum visit is complete, patients can continue to see the midwife for women's health/contraception needs, or she can see their PCP for any other needs.</p> <p><b>Wheaton Franciscan</b> The clinic works with many different PCPs and pediatricians in the community. If the patient has an assigned PCP, we will notify them that the patient has delivered. We still provide some primary care and inter-conception care for our patients and have established a close relationship with the family care center to help women transition to a PCP.</p>
	<b>Reporting to DHS</b>	Reporting to DHS will be done semi-annually according to the contract.
	<b>Payment Structure</b>	Payment structure will be followed as described in the contract.

<b>HMO Representative</b>	
1. Identify the HMO staff person in charge of overseeing the implementation of the Medical Home Pilot.	<b>Abri</b> Patricia Delaney, RN, CCM

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